Bath & North East Somerset Council

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Date: 14th Mar 2013
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To: All Members of the Wellbeing Policy Development and Scrutiny Panel

Councillor Vic Pritchard
Councillor Katie Hall
Councillor Lisa Brett
Councillor Eleanor Jackson
Councillor Anthony Clarke
Councillor Bryan Organ
Councillor Kate Simmons
Councillor Sharon Ball
Councillor Douglas Nicol

Chief Executive and other appropriate officers
Press and Public

Dear Member

Wellbeing Policy Development and Scrutiny Panel: Friday, 22nd March, 2013

You are invited to attend a meeting of the **Wellbeing Policy Development and Scrutiny Panel**, to be held on **Friday, 22nd March, 2013** at **10.00 am** in the **Council Chamber - Guildhall, Bath.**

Note: Members of the Panel will have a private meeting at 9.30am in the same room.

The agenda is set out overleaf.

Yours sincerely

Jack Latkovic
for Chief Executive

If you need to access this agenda or any of the supporting reports in an alternative accessible format please contact Democratic Services or the relevant report author whose details are listed at the end of each report.

This Agenda and all accompanying reports are printed on recycled paper

NOTES:

1. **Inspection of Papers:** Any person wishing to inspect minutes, reports, or a list of the background papers relating to any item on this Agenda should contact Jack Latkovic who is available by telephoning Bath 01225 394452 or by calling at the Riverside Offices Keynsham (during normal office hours).

2. **Public Speaking at Meetings:** The Council has a scheme to encourage the public to make their views known at meetings. They may make a statement relevant to what the meeting has power to do. They may also present a petition or a deputation on behalf of a group. Advance notice is required not less than two full working days before the meeting (this means that for meetings held on Wednesdays notice must be received in Democratic Services by 4.30pm the previous Friday)

   The public may also ask a question to which a written answer will be given. Questions must be submitted in writing to Democratic Services at least two full working days in advance of the meeting (this means that for meetings held on Wednesdays, notice must be received in Democratic Services by 4.30pm the previous Friday). If an answer cannot be prepared in time for the meeting it will be sent out within five days afterwards. Further details of the scheme can be obtained by contacting Jack Latkovic as above.

3. **Details of Decisions taken at this meeting** can be found in the minutes which will be published as soon as possible after the meeting, and also circulated with the agenda for the next meeting. In the meantime details can be obtained by contacting Jack Latkovic as above.

   Appendices to reports are available for inspection as follows:-

   Public Access points - Riverside - Keynsham, Guildhall - Bath, Hollies - Midsomer Norton, and Bath Central, Keynsham and Midsomer Norton public libraries.

   For Councillors and Officers papers may be inspected via Political Group Research Assistants and Group Rooms/Members' Rooms.

4. **Attendance Register:** Members should sign the Register which will be circulated at the meeting.

5. THE APPENDED SUPPORTING DOCUMENTS ARE IDENTIFIED BY AGENDA ITEM NUMBER.

6. **Emergency Evacuation Procedure**

   When the continuous alarm sounds, you must evacuate the building by one of the designated exits and proceed to the named assembly point. The designated exits are sign-posted.

   Arrangements are in place for the safe evacuation of disabled people.

Wellbeing Policy Development and Scrutiny Panel - Friday, 22nd March, 2013

at 10.00 am in the Council Chamber - Guildhall, Bath

A G E N D A

1. WELCOME AND INTRODUCTIONS

2. EMERGENCY EVACUATION PROCEDURE

   The Chair will draw attention to the emergency evacuation procedure as set out under Note 6.

3. APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

4. DECLARATIONS OF INTEREST

   At this point in the meeting declarations of interest are received from Members in any of the agenda items under consideration at the meeting. Members are asked to indicate:

   (a) The agenda item number in which they have an interest to declare.

   (b) The nature of their interest.

   (c) Whether their interest is **a disclosable pecuniary interest** *or* an **other interest**, (as defined in Part 2, A and B of the Code of Conduct and Rules for Registration of Interests)

   Any Member who needs to clarify any matters relating to the declaration of interests is recommended to seek advice from the Council's Monitoring Officer before the meeting to expedite dealing with the item during the meeting.

5. TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIRMAN

6. ITEMS FROM THE PUBLIC OR COUNCILLORS - TO RECEIVE DEPUTATIONS, STATEMENTS, PETITIONS OR QUESTIONS RELATING TO THE BUSINESS OF THIS MEETING

   At the time of publication no notifications had been received.

7. MINUTES 28TH JANUARY 2013 (Pages 7 - 16)

To confirm the minutes of the above meeting as a correct record.

8. CABINET MEMBER UPDATE (15 MINUTES)

The Panel will have an opportunity to ask questions to the Cabinet Member and to receive an update on any current issues.

9. HOMELESSNESS & THE USE OF TEMPORARY ACCOMMODATION (30 MINUTES) (Pages 17 - 22)

The Council has a duty to provide temporary accommodation for people who are homeless, have a local connection, are in priority need for accommodation and who did not become homeless intentionally. At the request of panel this report aims to provide an update on the current demands around homelessness and specifically temporary accommodation.

The Wellbeing Policy Development & Scrutiny Panel is asked to note the report.

10. CLINICAL COMMISSIONING GROUP UPDATE (15 MINUTES)

The Panel will receive an update from the Clinical Commissioning Group (CCG) on current issues.

11. BATH AND NORTH EAST SOMERSET LOCAL INVOLVEMENT NETWORK (LINK) UPDATE (15 MINUTES)

The Panel are asked to consider an update from the BANES Local Involvement Network.

12. HEALTHWATCH AND INDEPENDENT COMPLAINTS ADVOCACY SERVICE (ICAS) (15 MINUTES) (Pages 23 - 62)

This report describes the outcome of the process for procuring a provider for Healthwatch B&NES (Local Healthwatch), and the provision of an NHS complaints advocacy service (ICAS), both from 1st April 2013. The provision of a Local Healthwatch service and an NHS complaints advocacy service are statutory requirements of the Health and Social Care Act 2012.

Members are ask to note the information presented.

LUNCH BREAK 11:30-11:45

13. PROVISION OF NEURO-REHABILITATION AT THE ROYAL NATIONAL HOSPITAL FOR RHEUMATIC DISEASES (2 HOURS) (Pages 63 - 94)

Purpose of the Report -

To report to the Bath and North East Somerset (B&NES) Wellbeing Policy Development and Scrutiny Panel:

- the proposed re-provision of specialised neuro-rehabilitation services (inpatient and outpatient) provided at the Royal National Hospital for Rheumatic Diseases (RNHRD's) from April 1st 2013;
- that additional capacity for the provision of level 1/2A neuro-rehabilitation has been identified and agreed in principle with two alternative providers at Level 1 and a wider range of providers at Level 2A to ensure continuous provision from 1st April should scrutiny vote to support this interim re-provision proposal;
- that a programme of stakeholder (patients, carers, public, RNHRD staff and providers) engagement on the short- and long-term provision of neuro-rehabilitation in the South West has been carried out, with due regard given to two extensive reviews of local services recently carried out by Somerset and Devon Local Involvement Networks.

(This paper should be read in conjunction with the Bath & North East Somerset Primary Care Trust's briefing on the re-provision of the non-specialised Outpatient Neuro-rehabilitation service – marked as part 2).

The B&NES Wellbeing Policy Development and Scrutiny Panel is asked to:

- note that patients from the South West have and will continue to receive the best quality neuro-rehabilitation services that the NHS is able to provide;
- note there have been no issues regarding quality or safety in the RNHRD's decision to cease providing neuro-rehabilitation after the 31st March 2013;
- note the continued high level of quality care and family experience that the recommendations are able to support;
- note commissioners' collaboration with key stakeholders, including patients and the public as well as potential providers, in developing the recommended re-provision option;
- note that proposals should maintain the existing high quality of care without any adverse effect on current in-patients or future access to the service;
- support the proposal for service re-provision in the proposed centres.

The Panel also requested from the Royal National Hospital for Rheumatic Diseases to provide their view on the part they played in the process for the future of the Neuro Rehabilitation Services (attached as 'Update from the RNHRD').

14. WORKPLAN (Pages 95 - 102)

This report presents the latest workplan for the Panel.

The Committee Administrator for this meeting is Jack Latkovic who can be contacted on 01225 394452.

BATH AND NORTH EAST SOMERSET

WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL

Monday, 28th January, 2013

Present:- Councillors Vic Pritchard (Chair), Katie Hall (Vice-Chair), Lisa Brett, Eleanor Jackson, Anthony Clarke, Bryan Organ, Douglas Nicol, Caroline Roberts and Brian Simmons

Also in attendance:

72 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting.

73 EMERGENCY EVACUATION PROCEDURE

The Chairman drew attention to the emergency evacuation procedure.

74 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

Councillor Sharon Ball sent her apologies and was substituted by Councillor Caroline Roberts.

Councillor Kate Simmons sent her apologies and was substituted by Councillor Bryan Simmons.

Councillor Simon Allen – Cabinet Member for Wellbeing, sent his apologies to the Panel.

75 DECLARATIONS OF INTEREST

Councillor Eleanor Jackson declared an ‘other’ interest as a Council representative on Sirona Care and Health Community Interest Company.

Councillor Vic Pritchard declared an ‘other’ interest as a Council representative on Sirona Care and Health Community Interset Company.

Councillor Anthonty Clarke declared a ‘disclosable pecuniary interest’ in item 11 (Item 14 on the revised agenda) ‘THE ROYAL NATIONAL HOSPITAL FOR RHEUMATIC DISEASES IN BATH – UPDATE’. Councillor Clarke withdrew from the meeting for the duration of this item.

Councillor Caroline Roberts declared an 'other' interest in 11 (Item 14 on the revised agenda) 'THE ROYAL NATIONAL HOSPITAL FOR RHEUMATIC DISEASES IN BATH – UPDATE' as she is married to an employee of the Royal United Hospital.

76 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIRMAN

There was none.

77 ITEMS FROM THE PUBLIC OR COUNCILLORS - TO RECEIVE DEPUTATIONS, STATEMENTS, PETITIONS OR QUESTIONS RELATING TO THE BUSINESS OF THIS MEETING

1. Mr Greg Hartley-Brewer made a statement to the Panel on the subject of 'Non-Provision of Mandatory NHS Dental Treatments in B&NES Particularly ADP Oldfield Park and ADP Twerton Dental Practices'. A copy of the statement can be found on the Panel's Minute Book.

   The Panel asked the following factual questions:

   Councillor Hall asked if there was evidence of the dental practices described being more widespread than Oldfield Park. Mr Hartley-Brewer stated that it could be happening elsewhere as there was no standard monitoring of Band 1 treatments. He stated that he could not say for certain.

2. Ms Mary-Anne Darlow representing 'Headway Bath' made a statement to the Panel on the subject of the proposed closure of the specialist Neuro Rehabilitation Unit at the Royal National Hospital for Rheumatic Diseases (relating to item 11 on the agenda. Item 14 on the revised agenda). A copy of the statement can be found on the Panel's Minute Book.

   The Chairman thanked the members of the public for the statements. It was noted that the Panel wished to put an item on each of the above issues on it's future work plan ('Workplan' Item 17).

78 MINUTES 16TH NOVEMBER 2012

Following some corrections, the Panel confirmed the minutes of the previous meeting as a true record and they were duly signed by the Chairman.

79 CABINET MEMBER UPDATE

Jane Shayler – Programme Director for Non-Acute Health, Social Care and Housing read the update on behalf of Councillor Simon Allen – Cabinet Member for Wellbeing. The update (which is available in full on the Panel's minute book) covered the following:

- Winter Warmth Club – Stay warm this winter
- Homelessness and Use of Temporary Accommodation
- Response to 'Winter Pressures' Demand for Health and Social Care
- Implementation of the National Resource Allocation System (RAS)

Panel members raised the following points and asked the following questions:

Councillor Pritchard asked if, in relation to the 'Winter Pressures', the "Section 256" funding was new money. The Director responded that it was an additional allocation and that the allocation for next year had also been confirmed. Councillor Pritchard stated that the Council would be in a difficult position if this funding stopped. The officer confirmed that the 'Section 256' funding was a one off payment which is confirmed on an annual basis which makes long term planning difficult.

Councillor Pritchard referred to the 'Homelessness and Use of Temporary Accommodation' item. He explained that he had asked about the current homelessness situation at a Cabinet meeting and that the Cabinet member was, by his own admission, vague in determination of homelessness. Councillor Pritchard stated that, considering the significant national increase in homelessness, he wanted a more detailed answer from the Cabinet Member. It was suggested that the Cabinet Member be invited to the next meeting of the Panel to answer some questions on this. Councillor Jackson added that it would be useful to also invite Graham Sabourn – Associate Director Housing. Councillor Brett added that she would like some information about B&NES approach to housing people with learning difficulties.

Councillor Hall referred to the 'Winter Warmth/Fuel Poverty' item. She explained that social media and the press was used by Sirona to give advice during the recent cold snap and asked how successful this had been. The Director said she would find out and come back at a later date with the response.

Councillor Jackson explained that she had been stuck on a bus during the cold snap and another passenger with a computer could not get any response from B&NES. She explained that there had to be other ways to contact people other than Twitter as not everyone had access. Councillor Jackson went on to explain that she had found rough sleepers and that Julian House was unable to help until the next morning. Councillor Jackson stated that the Council should think about employing a detached worker. She added that there were 22 young people 'sofa surfing' in her ward and that the problem should not be underestimated.

Councillor Brett stated that the RUH saw 250 fractures in a single week related to the snow and ice and asked if there was a case for gritting pavements. Tracy Cox – B&NES PCT (Primary Care Trust) stated that a case could be made for this.

80 BATH AND NORTH EAST SOMERSET LOCAL INVOLVEMENT NETWORK (LINK) UPDATE

Jayne Pye from Bath and North East Somerset Local Involvement Network (Link) updated the Panel making the following points (a copy of the full update is available on the minute book):

- "On the 30th November the Care Forum were appointed as hosts of Link until the 31st March when Healthwatch comes into being. Link meetings will take place on the 12th February and 26th March. There will be a stakeholder event looking at the work that Link has undertaken and the legacy that will be

passed on to Healthwatch. The Care Forum is administering e-bulletins monthly. An annual report will also be produced.

- Work continues in the following areas – work with the National Autistic Society; visits to two care homes; representation on various groups such as AWP stakeholder group, Health and Wellbeing Board, Strategy Group for Transition, Dignity Group at the RUH etc.

- On the 20th December the Royal Mineral Hospital Board voted to close the Neuro Rehabilitation ward for financial reasons. There is an intention for the ward to be closed on the 31st March 2013. Link was not involved in the consultation. There are concerns for patients past present and future. Link wished to understand how the consultation process had been undertaken and is awaiting dates for a meeting with Kirsty Matthews – Chief Executive, on this. A meeting between specialist commissioning, the CCG (Clinical Commissioning Group) and Link regarding what happens to the patients needing this service and consultation arrangements is being organised.

- The Re-ablement and Post Discharge Support Project has had positive outcomes. I will be visiting a number of those who have received this service and talk to them about how they see the service, could we have done things differently, are there changes to make before a commissioned service specification is defined.

- We continue to meet with CQC (Care Quality Commission) and the CCG and have invited Dr Ian Orpen to share their patient and public involvement strategy on the 26th March at the Link legacy conference."

The Chairman noted that much of the content of this presentation (on the Neuro-Rehab unit at the RNHRD) would be debated at item 11 (revised agenda item14).

The Chairman thanked Jayne Pye for her contribution. Councillor Jackson added that Janye had made a huge contribution to meetings of the Panel and had enhanced the Panel understanding of the patient experience.

81 CARE QUALITY COMMISSION (CQC) UPDATE

Karen Taylor – Compliance Manager, Care Quality Commission (CQC) made a presentation to the Panel and covered the following points:

- The Local B&NES Team
- Protecting people from poor care
- Scale of CQC regulated care
- Roles and responsibilities – CQC's place in the system
- PDS Panel and CQC local relationship

- Approach to inspections
- CQC – what CQC does and does not do
- We are reviewing our strategy
- What external scrutiny told us
- Contacts

Panel members raised the following points and asked the following questions:

Councillor Pritchard asked about the Panel's relationship with the CQC. Karen Taylor stated that she wished to establish this as it may not always be appropriate to report to full Panel. She asked that Panel members pass on any concerns about the way local services are being provided.

Councillor Pritchard asked what kind of penalty there is for inappropriate service. Karen Taylor explained that the Local Authority has the responsibility for safeguarding, the CQC are concerned with the way services are provided. She further explained that the CQC liaise with providers and if failings are found, a compliance obligation is issued and published. This is usually very effective. Penalty notices and fines can also be issued.

It was **RESOLVED** that:

- The Chair/Panel receive a programme of planned reviews; and
- The Panel are sent a link to the revised strategy; and
- Karen Taylor and the Democratic Services Officer for the Panel (Jack Latkovic) speak about ways the CQC can feed into the work of the Panel.

82 WINTERBOURNE VIEW FINDINGS UPDATE

Jane Shayler – Programme Director for Non-Acute Health, Social Care and Housing introduced the report. She explained that she had received some written questions from Councillor Brett and that the Panel would be sent a brief written response. Jayne Pye of LINK asked if she could be copied in on this briefing note.

Panel members raised the following points and asked the following questions:

Councillor Pritchard noted that B&NES did not have anyone at 'Winterbourne View' at the time that the review is concerned with. The Director reported that this authority does not use residential care very often. She explained that follow up reviews had been done with people who had been with Castle Beck (the provider). The Director explained that she is not complacent and that lessons can always be learned from cases such as this.

Councillor Pritchard stated that during the period of his involvement there had initially been an assumed level of comfort regarding safeguarding that could have perhaps been challenged. Since B&NES has applied the new national discipline on safeguarding, the authority has a new and warranted confidence. We were very fortunate to not have had any involvement in Winterbourne View but appreciate the opportunity to learn lessons.

83 JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) - SOCIAL AND ECONOMIC INEQUALITIES

Jon Poole and Helen Tapson made a presentation to the Panel covering the following (a full copy of the slide presentation is available on the minute book):

- Background – what is the Joint Strategic Needs Assessment
- The Local Picture
- What are socio-economic inequalities
- Life Course
- Life Expectancy
- Community Voice
- What is being done?
- Recommendations

Panel members raised the following points and asked the following questions:

Councillor Eleanor Jackson stated that the information was useful but that one of the greatest causes of poverty in her ward was due to the breadwinner becoming ill. Councillor Organ agreed that the information is too generalized. Councillor Pritchard stated that this kind of information provides a useful starting point with which to target resources. Councillor Brett asked if the findings could be circulated to all 'not for profit' organisations in the area and Policy and Partnerships.

Councillor Simmonds asked the age of the data. Jon Poole explained that the life expectancy data was from 2009/10 and the hospital admissions data was from 2012.

84 NHS AND CLINICAL COMMISSIONING GROUP UPDATE

Dr Ian Orpen, Chair of the Clinical Commissioning Group, introduced the update paper to the Panel. A full copy of the update report is available on the minute book. The Update report covered the following:

- Appointments to the CCG's governing body
- Authorisation
- Commissioning Support Service
- Commissioning Intentions
- Urgent Care
- NHS 111
- Winter Pressures
- Specialised Services – Review of Vascular Provsion

Panel members raised the following points and asked the following questions:

Councillor Pritchard asked about the transition to 111. Dr Orphen explained that he was confident that new providers are in place. He explained that during the bedding

in period, there was likely to be some extra workload. He explained that the national campaign would be rolled out in October 2013.

Councillor Pritchard asked about the Vascular Review, he said that this concerned a small number of patients but could be a significant imposition if people from rural areas were being asked to travel to the BRI (Bristol). Dr Orpen explained that a B&NES patient would go to the BRI or North Bristol Trust and be transferred back to the RUH once the operation is done. How the patient got to the hospital in Bristol would depend on the way they entered the system eg. as an emergency case, they would be taken in the ambulance.

Councillor Brett asked for an update on Urgent Care in terms of outreach, homelessness. She also asked if the CCG would be financially disadvantaging the RUH in any way. Dr Orphen answered that this would only happen if a service was no longer based at the RUH.

Councillor Brett asked what the CCG are going to do to mitigate the risk of the 250 fractures happening in future years. Dr Orphen replied that this is a wider debate but that the CCG would back any move to mitigate the problem.

Councillor Clarke asked if the Panel should have access to the impact assessment regarding B&NES patients going to Bristol for services. Tracy Cox explained that the review process is about to start and an impact assessment would be brought back to the Panel.

Councillor Jackson had some concerns about Harmoni. Dr Orphen assured the Panel that there had been communication with the Department of Health and Harmoni and this had been positive.

Councillor Jackson referred to a Guardian article about Familial hypercholesterolaemia (FH) screening. Dr Orphen explained that there were no immediate plans for this but that he was always horizon scanning.

It was **RESOLVED** that the Impact Assessment regarding the Vascular Review be submitted to the panel as soon as it becomes available.

85 THE ROYAL NATIONAL HOSPITAL FOR RHEUMATIC DISEASES IN BATH UPDATE

(Note: Councillor Anthony Clarke withdrew from the meeting for this item having declared a disposable pecuniary interest)

Kirsty Matthews – Chief Executive RNHRD, made a presentation to the Panel covering the following (a full copy of the slide presentation is available on the minute book):

- Our position as a foundation trust

- Money not services
- Finding a solution?
- The decision – we expect to join with the RUH
- How will this happen?
- Transition process – progress to date
- Risks and opportunities
- Shape of the services 2013
- Successes at the Min
- Communication and information
- Coming together – Vision for the future

The Panel noted that they had been sent a statement on the concerns of the RNHRD Governors' for the future of the Neuro-Rehabilitation patients.

Panel members raised the following points and asked the following questions:

Councillor Pritchard asked about the nature of 'acquisition' as opposed to 'merger'. He stated that if it is an acquisition, the RUH might want to lose elements of the Min (RNHRD) because of the business considerations of the hospital. Councillor Pritchard noted that he had never heard a criticism of the Min and that people go out of their way to praise its valuable service. Councillor Pritchard stated that, regarding public perception, the fact that the Neuro-Rehab unit could close so early in the process of acquisition, it may similarly lead to concerns of the possible loss of other services. Kirsty Matthews – RNHRD Chief Executive explained that, due to the size of the Min compared to the RUH, it was not the classic definition of a merger and the legal term 'acquisition' was more appropriate. She explained that the working relationship with the RUH was good.

Councillor Pritchard asked about the public perception of the acquisition, he asked if there would be two sites or would the buildings be merged. He stated that he felt that the Min should retain its individual identity. Councillor Hall stated that she felt it was the continuation of the service that was most important, rather than the badge. James Scott – Chief Executive RUH explained that the Min and RUH are currently separate legal entities. He explained that the question regarding the future identity of the hospitals was many steps ahead of the process at the present time and for the acquisition to go ahead, the RUH had to become a Foundation Trust and this would not happen until early summer.

Councillor Brett asked what the business case for the RUH was in going forwards with the acquisition. James Scott explained that the RUH do not have a rheumatology section and that in terms of research and development, it was not a university hospital although it was research active. He stated that the acquisition would address these points. He further explained that the acquisition was in the final phase and the outcome should be clear in 6-8 weeks.

Councillor Nicol asked why the current budget situation was not foreseen. Kirsty Matthews – RNHRD Chief Executive explained that there had been strong indications about the change in commissioning intentions. She explained that there had been work done to reduce overheads but it had not had a significant enough

effect. Councillor Nicol stated that he would like to look at the speed with which the acquisition will go through.

Councillor Jackson stated that the Min is in a Grade 1 listed building and it would be much cheaper to work from a more modern building

Discussion on the Neuro-Rehab Unit

Councillor Organ stated his concerns about the closure of the Neuro-Rehab unit. Councillor Hall stated that this Panel should have been included in the consultation. She stated that the figures were not good and asked how sustainable the hospital is over the next 6 months. The Chief Executive of the RNHRD stated that the majority of work is outpatient based and the changes regarding Neuro-Rehab would change the shape of the hospital. Councillor Hall asked about special commissioning regarding the Neuro-Rehab unit. The Chief Executive explained that there had been some dialogue with the specialist commissioning team and that the new position should be clear in early February 2013. She stated that she was working with LINK; had engaged with staff and was considering meeting with families. She noted the tight timescale. Councillor Hall asked what would happen if specialist commissioning was not in place by 1st April 2013. Tracey Cox (PCT) explained that there are alternative potential providers; some may not be close to this area. Councillor Hall commented that a typical six week stay is a long time to be in a distant location.

Following a question from Councillor Simmons regarding the number of outpatients treated at the Neuro-Rehab unit, the Chief Executive explained that there were two types, the former inpatient and the non-inpatient. She stated that by the end of March 2012 there had been 240 attendances in total, 90 of which were linked to an inpatient stay.

Councillor Pritchard stated that the intention was to close the Neuro-Rehab unit on 31st March 2013 and other area providers may not be able to accommodate extra patients. He explained that staff at the unit have had notice of intent, the consultation period had been over the Christmas period and that LINK did not feel they had appropriate opportunity to comment.

On a proposal from Councillor Pritchard, seconded by Councillor Organ, it was:

RESOLVED that there would be an extra ordinary meeting of the Panel to consider the intentions and possible outcomes of the closure of the Neuro-Rehabilitation Unit at the RNHRD.

Councillor Pritchard thanked everyone for coming and for the information shared.

86 SUBSTANCE MISUSE SERVICES

Jane Shayler – Programme Director for Non-Acute Health, Social Care and Housing and Carol Stanaway – Substance Misuse Commissioning Manager introduced the report.

Panel members raised the following points and asked the following questions:

Councillor Pritchard stated that it was an excellent report. He asked how outreach workers persuaded users to come in to the service. Carol Stanaway said there were lots of ways and that they had distributed cards with harm reduction messages, they used Project 28 and the use of peer advocates was effective.

Councillor Brett asked how the probation service was getting involved. The officer explained that she worked well with them and they helped to support offenders. She explained that there had been some significant success with alcohol treatment processes which had also proved cost effective.

Councillor Jackson asked if the work was cross border. The officer explained that people would not be turned away.

Councillor Pritchard congratulated Carol Stanaway and the service and also Project 28.

87 WORKPLAN

Following the additions shown below, they Panel noted the future workplan:

- Sexual Health (Councillor Clarke)
- RNHRD – Update on the Acquisition
- Temporary Accommodation and Homelessness – invitation to the Cabinet Member for Homes and Planning (Councillor Tim Ball)
- Dentistry
- Extra meeting – Neuro-Rehab Unit (RNHRD)
- Vascular Review – Impact Assessment

The meeting ended at 3.00 pm

Chair(person) .....

Date Confirmed and Signed .....

Prepared by Democratic Services

Bath & North East Somerset Council	
MEETING:	Wellbeing Policy Development & Scrutiny Panel
MEETING DATE:	22nd March 2013
TITLE:	Homelessness & the use of Temporary Accommodation
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: None	

1 THE ISSUE

1.1 The Council has a duty to provide temporary accommodation for people who are homeless, have a local connection, are in priority need for accommodation and who did not become homeless intentionally. At the request of panel this report aims to provide an update on the current demands around homelessness and specifically temporary accommodation.

2 RECOMMENDATION

The Wellbeing Policy Development & Scrutiny Panel is asked to note the report.

3 FINANCIAL IMPLICATIONS

3.1 There are no direct financial implications arising from this report. However, it should be noted that any change in demand for housing advice services and in particular temporary accommodation, would ultimately have significant financial impacts.

4 THE REPORT

Background Information

4.1 The Council has a duty to provide temporary accommodation for people who are homeless, have a local connection, are in priority need for accommodation and who did not become homeless intentionally. People with a priority need include people with dependant children, pregnant women, and anyone who is vulnerable because of old age, mental illness, handicap or physical disability or other special reason. The Homelessness (Priority Need for Accommodation)(England) Order 2002 broadened the definition of priority need to include 16 and 17 year olds, care leavers and people who are vulnerable as a result of being in custody or threats of violence.

4.2 Temporary accommodation is a blanket term which can include:

(1) bed & breakfast accommodation,

(2) accommodation occupied on a licence e.g. hostel accommodation,

(3) accommodation occupied on an assured shorthold tenancy e.g. flat or house.

4.3 As these last two types of temporary accommodation are usually run in partnership with not-for-profit housing providers, they are referred to as temporary accommodation schemes. Bath & North East Somerset currently uses all of the above types of temporary accommodation. The temporary accommodation schemes are commissioned through Curo Housing and they provide 28 units of accommodation.

4.4 In addition the Council also commissions a range of services to assist rough sleepers. These are often people who are homeless but where the Council does not have a duty to provide temporary accommodation. This report does not address this area of work.

National and Sub-Regional Context

4.5 Bath and North East Somerset Council have a relatively low rate of households in temporary accommodation in comparison to the mean of England and the other authorities in the sub-region, as shown in figure 1 below. The chart uses the most recent national data set information which is September 2012. However it should be noted that locally the number of households in temporary accommodation has increased since September 2012 and so it is likely that the performance gap will have narrowed slightly.

Local Perspective

4.6 In recent years housing Services have adopted a prevention strategy for dealing with homelessness, working hard to maintain existing accommodation and where

necessary sourcing alternative accommodation through either the Council's Homefinders Scheme or if a young adult the Supported Lodgings Scheme. Only as last resort are households placed in temporary accommodation. As a result the number of households in temporary accommodation has decreased significantly over recent years as shown in figure 2 below.

Figure 1: National and Sub-Regional Context

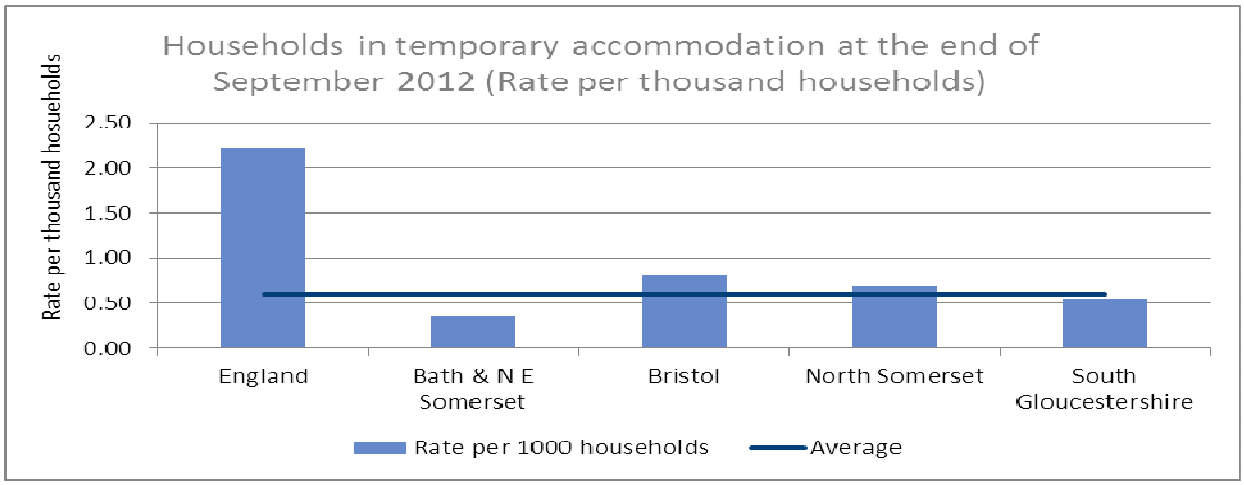
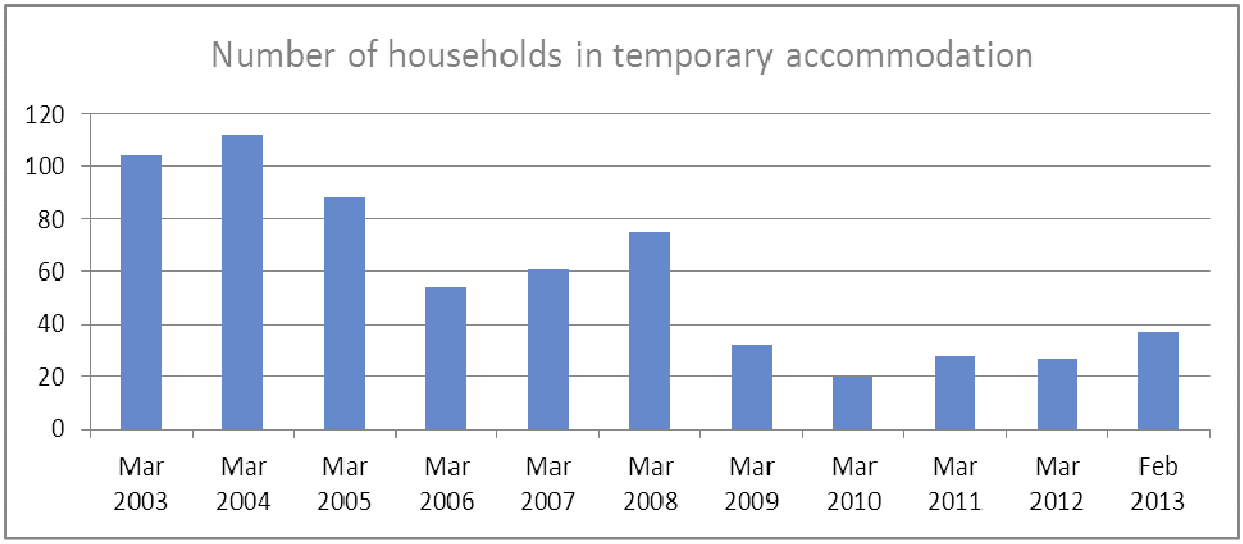
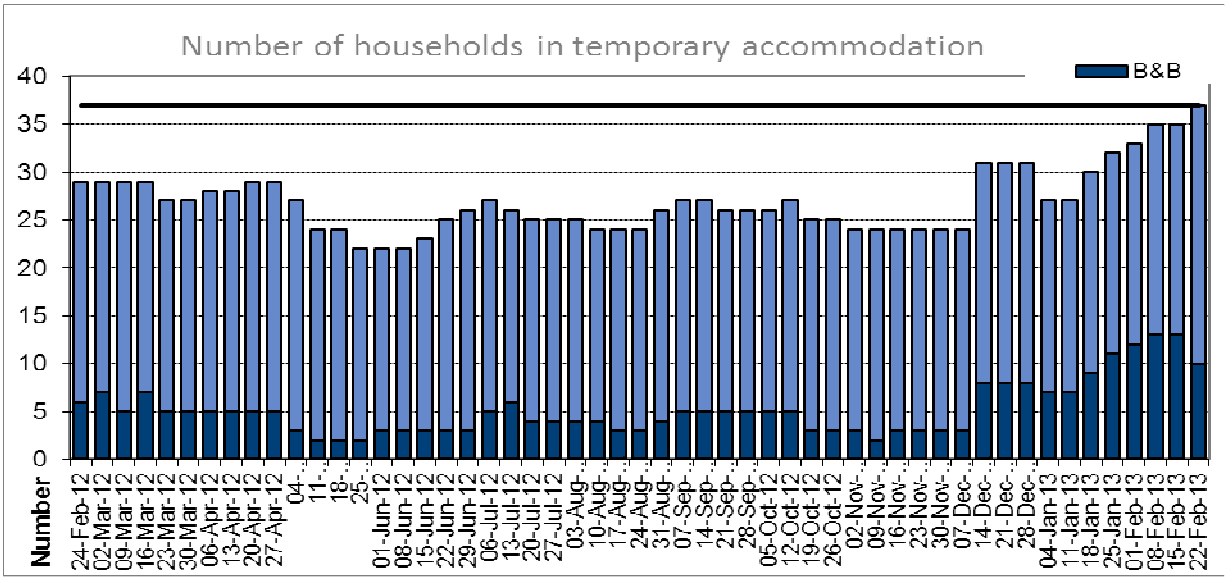


Figure 2: Number of Households in Temporary Accommodation (10 yrs)



4.7 However, since the beginning of the year there has been a significant increase in the number of households in temporary accommodation, as demonstrated in figure 3 below.

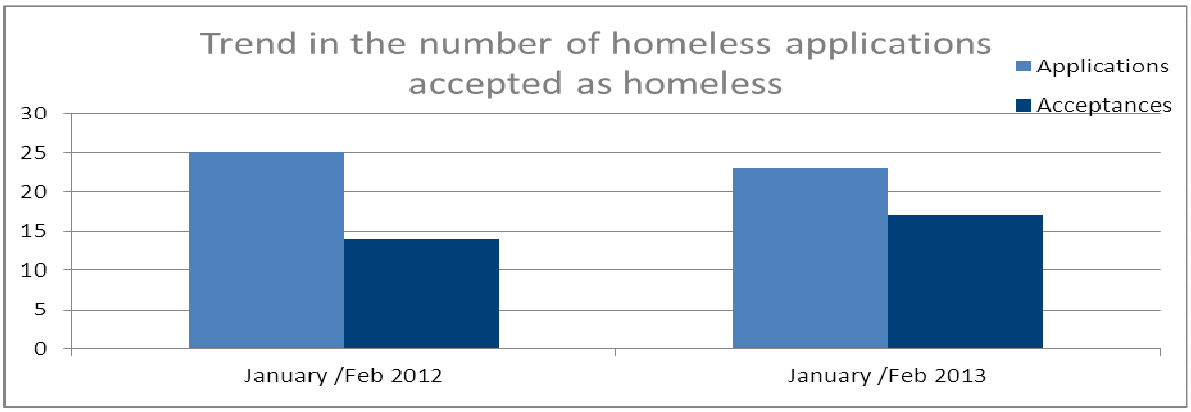
Figure 3: Number of Households in Temporary Accommodation (1 year)



4.8 The numbers of households in temporary accommodation are determined by two fundamental factors. These factors are:

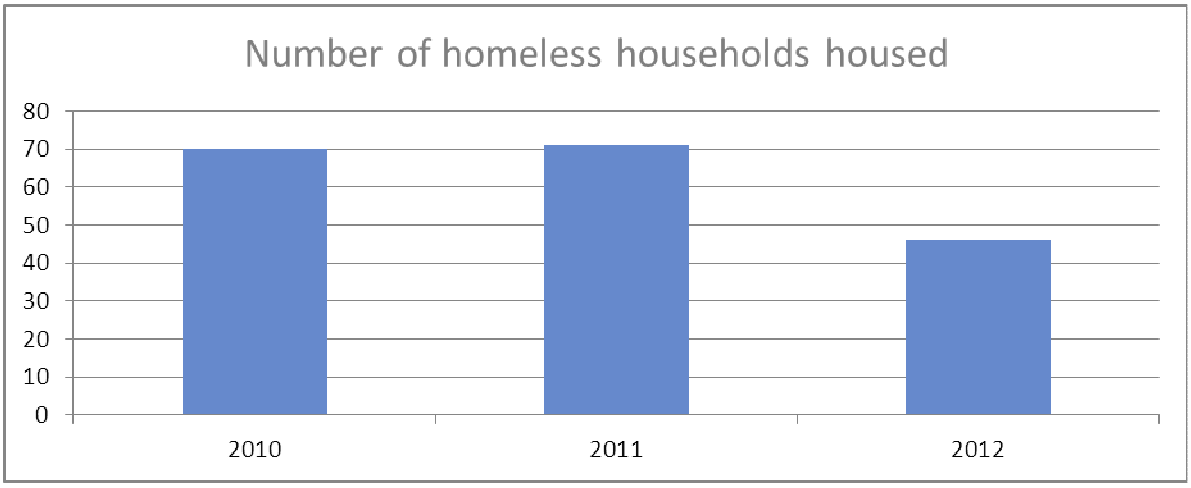
4.9 The numbers of homelessness acceptances have been relatively stable, recording 14 in 2012 and 17 in 2013 for the same period (see figure 4). Whereas the number of households in temporary accommodation housed through Homesearch has decreased significantly.

Figure 4: Trend in Homeless Acceptances



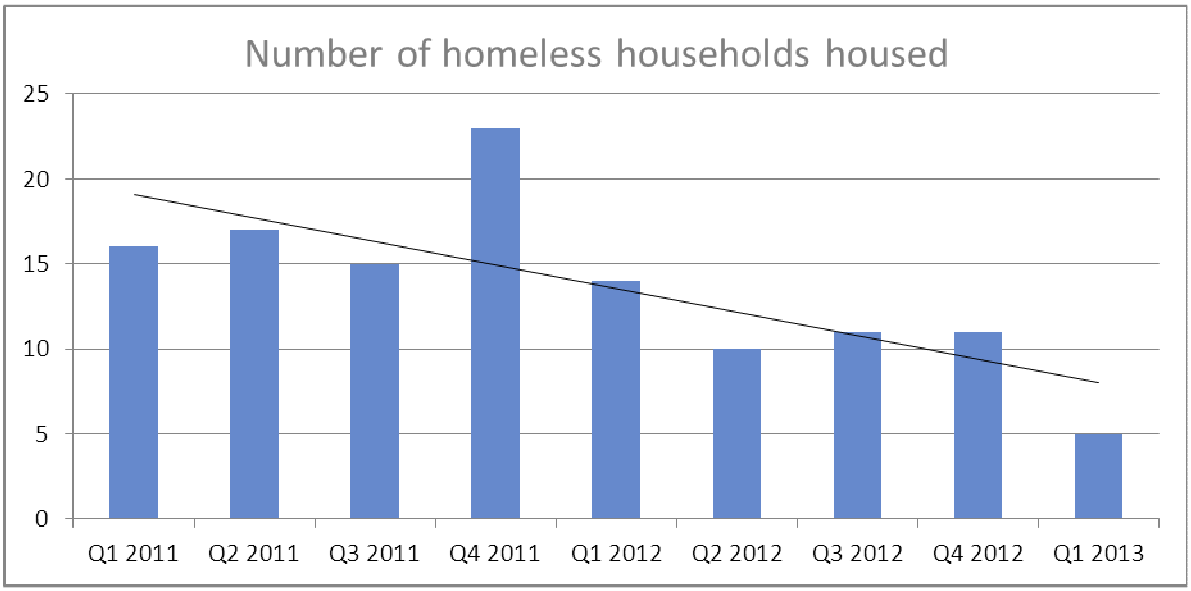
4.10 In 2012, 46 household in temporary accommodation were housed by Homesearch. If you compare this figure to the previous two years, it equates to a fall from 71 households housed by Homesearch (see figure 5).

Figure 5: Households Housed (Annual data)



4.11 When examining the figures in more detail it shows that in 2012 the months of October, November resulted in a low number of homeless people being housed by Homesearch. Apart from an increase in December, this trend has continued for January and February 2013 where in some months only 1 homeless household was housed by Homesearch (see figure 6).

Figure 6: Homeless households housed (Quarterly data)



4.12 As part of the Council's transformation project Housing Services are currently reviewing how the Housing Options & Homeless team operate. As part of this review we will seek to ensure that a "move-on" role is incorporated into any future service design. This involves working with households in temporary accommodation to facilitate and encourage their "move-on" to permanent accommodation. This is a function that has operated successfully in the past and will ensure that households reside in temporary accommodation no longer than absolutely necessary.

4.13 Whilst it is outside of the scope of this paper it should be noted that the Government's welfare reform agenda is likely to further increase demand for the services of the Housing Options & Homeless team. This is at a time when the

Council, and hence the service, has to make additional financial savings. This is a particular consideration in the impending service redesign.

5 RISK MANAGEMENT

5.1 A risk assessment related to the issue and recommendations has not been undertaken due to the nature of this report, that is, an update report.

6 EQUALITIES

6.1 An Equality Impact Assessment has not been completed because the report aims to provide a briefing only and does not make recommendations for changes to provision, service delivery or policy.

7 CONSULTATION

7.1 Consultation has not been completed because the report aims to provide a briefing only and does not make recommendations for changes to provision, service delivery or policy.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Social Inclusion; Customer Focus; Young People; Human Rights; Other Legal Considerations

9 ADVICE SOUGHT

9.1 The Council's Monitoring Officer (Divisional Director – Legal and Democratic Services) and Section 151 Officer (Divisional Director - Finance) have had the opportunity to input to this report and have cleared it for publication.

Contact person	Graham Sabourn, Head of Housing Services. (Tel: 01225 477949)
Background papers	None
Please contact the report author if you need to access this report in an alternative format	

Bath & North East Somerset Council	
MEETING:	Wellbeing Policy Development & Scrutiny Panel
MEETING DATE:	22nd March 2013
TITLE:	Healthwatch and Independent Complaints Advocacy Service (ICAS)
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: Specification for the delivery of Healthwatch B&NES (Local Healthwatch) in Bath & North East Somerset	

1 THE ISSUE

This report describes the outcome of the process for procuring a provider for Healthwatch B&NES (Local Healthwatch), and the provision of an NHS complaints advocacy service (ICAS), both from 1st April 2013. The provision of a Local Healthwatch service and an NHS complaints advocacy service are statutory requirements of the Health and Social Care Act 2012.

2 RECOMMENDATION

Members are ask to note the information presented.

3 FINANCIAL IMPLICATIONS

3.1 The value of the 3-year contract for Healthwatch B&NES is £246,000 over the life of the contract. £72,000 has been included in the Policy & Partnerships base budget for each year and there is Local Healthwatch Grant funding of £40,422 for both 2013-14 and 2014-15.

3.2 The value of the 1-year contract for the NHS complaints advocacy service is £42,289. This is funded from Independent Complaints Advocacy Services Grant funding of £43,157 for 2013-14.

3.3 The above Grant funding streams will be received by Adult Social Care, as part of the new Local Reform and Community Voices Grant, and transferred to Policy & Partnerships.

4 THE REPORT

4.1 Under the Health & Social Care Act 2012, each local authority is required to provide a Local Healthwatch service to act as an independent consumer champion for health and social care, which will enable citizens and communities to influence and challenge how health and social care services are delivered within their locality. Local Healthwatch will replace the Local Involvement Networks (LINks) from 1st April 2013, but will carry forward and expand on their work.

4.2 The full specification for Healthwatch B&NES is contained in the appendix to this report.

4.3 The B&NES Local Healthwatch, known as Healthwatch B&NES, will have 2 seats on the Health and Wellbeing Board. This will ensure that the views and experiences of patients, carers and other service users are taken into consideration when local needs assessments and strategies are prepared, such as the Joint Strategic Needs Assessment (JSNA).

4.4 An invitation to tender for the provision of Healthwatch B&NES was issued on 13th November 2012, using the Council's Procurement Standing Orders process. Two responses were received by the deadline on 7th January 2013, and after having appraised the bids the assessment panel awarded the contract to The Care Forum. The Care Forum have been awarded contracts to deliver Local Healthwatch in Somerset, Bristol and South Gloucestershire.

4.5 One of the additional requirements of the Health and Social Care Act 2012 is that from 1st April 2013 each local authority makes provision for an advocacy service for complaints about any aspect of NHS services. Previously, this service (known as ICAS – Independent Complaints Advocacy Service) has been provided in B&NES by SEAP (Support, Empower, Advocate, Promote) under a direct commission with the Department of Health.

4.6 It has been agreed with our Audit and Risk Management department that the Council will commission SEAP to continue to provide the NHS complaints advocacy service for 12 months from 1st April 2013. During this time we will gain a better understanding of the requirements for an NHS advocacy service in B&NES, which in turn will enable a specification to be developed in order to tender for a supplier from 1st April 2014.

5 RISK MANAGEMENT

5.1 A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

6 EQUALITIES

An EqIA has been completed. No adverse or other significant issues were found.

7 CONSULTATION

7.1 Cllr Simon Allen; services users; Chair and Deputy Chairs of the LINk.

7.2 Consultation was carried out in face to face meetings.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Social Inclusion; Customer Focus; Sustainability; Young People; Other Legal Considerations

9 ADVICE SOUGHT

9.1 The Council's Monitoring Officer and Section 151 Officer (Divisional Director - Finance) have had the opportunity to input to this report.

Contact person	Susan Bowen 01225 477278
Background papers	Specification for the delivery of Local Healthwatch (Healthwatch B&NES) in Bath & North East Somerset
Please contact the report author if you need to access this report in an alternative format	

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Bath & North East Somerset Council

APPENDIX 1 -

Specification for the delivery of

Healthwatch B&NES (Local Healthwatch)

in

Bath & North East Somerset

Contract Reference No SWCE-8ZLJ95

Contents

1 INSTRUCTIONS AND INFORMATION

1.1 Background

This specification details a service requirement for an organisation to establish and run a fully-functioning Healthwatch B&NES from 1st April 2013 to 31st March 2016.

Bidders must utilise the Supplying the South West portal www.supplyingthesouthwest.org.uk as the vehicle to manage this procurement including the relaying of tender documents and to communicate messages so that a transparent, fair and consistent approach is demonstrated.

This Invitation to Tender (ITT) comprises:

- Section 1: Instructions and information;
- Section 2: Background to Requirements;
- Section 3: Specification;
- Section 4: Requirements of the Service Provider;
- Appendices 1,2,3,4 and 5: Appendix 2 contains the criteria showing the information required from bidders.

1.2 Tender Submission

On receipt of this ITT, bidders should examine all the documentation and report any apparent ambiguity or discrepancy in the documentation, and confirm on ProContract whether they intend to respond.

If a tenderer decides not to submit a tender, the tenderer should confirm on ProContract that they wish to opt out.

Any queries in connection with this invitation and associated documentation must be submitted using the 'Discussion' section of ProContract. Please ensure that you do not include any details that could identify your organisation, as the question and the response will be made available to all bidders (if relevant). Email or telephone enquiries will not be accepted.

Bidders are required to submit their tender via ProContract by the deadline shown on the Supplying the South West portal. Tenders submitted late or by any other means will not be accepted**.**

Prior to the date for the return of the tenders, the Council may clarify, amend or add to the tender documentation. Tenderers will be notified of any amendments via ProContract and all amendments shall form part of the tender documentation.

All tenders must be submitted in accordance with the following instructions in this section (1) and in Appendix 2.

Prior to the date for the return of the tenders, the Council may clarify, amend or add to the tender documentation. Any instruction will be issued through the Supplying the South West portal, 'Discussion' section, to every bidder and shall form part of the tender documentation. The bidder shall promptly acknowledge receipt of such instructions.

After submitting their bid, bidders may submit an amended bid at any point up to the deadline, and only the final version will be viewable by the Council. We therefore recommend submitting your bid at least 24 hours before the deadline.

Bidders must state whether any members or officers of the Council have any direct or indirect interest in your business or in the preparation or submission of their tender.

Tenders must be typewritten, preferably in Arial black 11 point, completed in English, and prices must be quoted in GBP sterling. Costs and prices submitted must be exclusive of VAT.

Prices quoted in the tender shall be deemed to include all taxes, duties, insurance premiums, guarantees or other costs associated with the provision and delivery of the services and exclude VAT if and where appropriate.

Tenders must be submitted by the time and date stated on ProContract. No extensions shall be granted to bidders for any reason.

1.3 Tender Evaluation and Award

Responses will be evaluated on the following quality/cost ratio:

Cost (see Appendix 1 below)	30%
Service Delivery (see Appendix 2 below)	70%

The preferred supplier will be the organisation with the highest overall score.

1.4 Scoring Classification

A total of 30% is available to the most competitive financial bid, with all other bids awarded marks on a pro-rata basis (i.e. the lowest bid cost, divided by your bid cost, then multiplied by 100). The weighting shall constitute 30% of the total tender score.

The following scoring mechanism will be used to allocate scores against responses contained in the Tender Submissions, which shall constitute 70% of the available marks:

Standard of Bidder Response	Score
Excellent standard of response; exceeds the requirements in a number of areas and is supported by strong evidence which gives the Council a high level of confidence.	8-10
Competent standard of response; meets requirements and is supported by a satisfactory level of evidence although there are a	4 - 7

few issues which give the Council cause for some minor concerns.	
Inadequate response; fails to meet some requirements and is generally unsatisfactory and/or has omissions and/or is not supported by evidence. Gives the Council cause for serious concern.	1 - 3
No response provided and/or substantial omissions which make the response fundamentally unacceptable and give the Council cause for major concern.	0

The Council are not bound to accept the overall best solution based on the methodology as described in this ITT. Nothing in this ITT shall require the Council to award a contract and the Council shall be able, at its sole discretion, to withdraw the ITT before the date for submission or withdraw from discussions at any stage.

1.5 Special Terms and Conditions

The Agreement will commence on 1st April 2013 and terminate on 31st March 2016 unless an option to extend is agreed by both parties, or unless the contract is terminated (see Terms and Conditions).

Bidders are responsible for obtaining all information necessary for the preparation of the tender. The Council will not reimburse or be responsible for any costs incurred by bidders in connection with the preparation or delivery of the tender.

Tenders must not be qualified, conditional, or accompanied by statements that could be construed as rendering them equivocal and/or placed on a different footing to those of other bidders. Only tenders submitted without qualification, in accordance with this invitation to tender will be accepted for consideration. The Council's decision on whether or not a tender is acceptable will be final and the bidder concerned will not be consulted. If a bidder is excluded from consideration, the bidder will be notified.

The tender documents must be treated as private and confidential. Bidders must not disclose the fact that they have been invited to tender or release details of the tender documents other than on an 'in confidence' basis to those who have a legitimate need to know or whom they need to consult for the purposes of preparing the tender.

Unless otherwise indicated the copyright in all tender documentation supplied with or pursuant to this invitation to tender belongs to the Council.

Bidders should note that copyright in this ITT rests with Bath & North East Somerset Council. The bidder shall treat all information contained within the ITT as strictly private and confidential, details of which should not be disclosed to any party, direct or indirect, except to the extent necessary for the preparation and submission of the tender.

Any bidder who directly or indirectly canvasses any member or officer of the Council or any of its advisers concerning the award of the contract for the provision of the services shall be disqualified.

Any bidder who:

- fixes or adjusts the amount of its tender by, or in accordance with, any agreement or arrangement with any other person; or

- communicates to any person, other than the Council, the amount of its proposed tender (except where such disclosure is made in confidence in order to obtain quotations necessary for the preparation of the tender, for insurance purposes); or

- enters into any agreement or arrangement with any other person that it shall refrain from tendering or that it should withdraw any tender once submitted or vary the amount of any tender to be submitted; or

- offers or agrees to pay or give or does pay or give any sum of money, inducement or valuable consideration directly or indirectly to any person for doing or having done or causing or have caused to be done in relation to this tender or any other tender or proposed tender or any other act or omission;

- Any unauthorised amendment, qualification or deletion of, or addition to the tender documents, issued by the Council, shall invalidate the tender shall be disqualified (without prejudice to any other civil remedies available to the Council and without prejudice to any criminal liability which such collusion may attract).

1.6 Equalities

The Council is committed to equality of opportunity as set out in the Corporate Equality Commitment. It is also committed to meeting its duty under the Equality Act 2010 and expects all contractors working with or providing a service for the Council to support the Council in meeting its obligations under the equality duty.

The Equality Duty

- Eliminate unlawful discrimination harassment, victimisation and other conduct prohibited by the Act
- Advance equality of opportunity by opportunity
- Foster good relations between people who share a characteristic and those who don't.

All goods, services and facilities will be undertaken in line with the Councils equality commitments.

The Council requires Contractors providing supplies, services or works on behalf of the council to adopt policies and practices that, at a minimum, comply with legislation, promote equality of opportunity in employment and service provision.

The Contractor shall notify the Council through the portal, and qualified in writing to the Council's Corporate Procurement Office, as soon as it becomes aware of any investigation of or proceedings brought against the Contractor under the Equality Act 2010 and the Human Rights Act 1998 or other relevant legislation.

Where any investigation is conducted or proceedings are brought under any of the equalities legislation which arise directly or indirectly out of any act or omission of the service provider, its agents or subcontractors, or the Staff, and where there is a finding against the service provider in such investigation or proceedings, the service provider shall indemnify the Council with respect to all costs, charges and expenses (including legal and administrative expenses) arising out of or in connection with any such investigation or proceedings and such other financial redress to cover any payment the Council may have been ordered or required to pay a third party.

1.7 Legal

The issue of this invitation to tender in no way commits the Council to award any contract pursuant to the tender process. The Council is not bound to accept the lowest or any tender and reserves the right to accept any tender, either in whole or in part or parts. Nothing in this invitation to tender shall require the Council to award a contract and the Council shall be able, at its sole discretion, to withdraw the invitation to tender before the date for submission or withdraw from discussions at any stage.

The fact that a tenderer has been invited to tender does not necessarily mean that it has satisfied the Council regarding matters raised in the pre-qualification questionnaire submitted and the Council reserves the right to return to any matter raised in the questionnaire as part of the formal tender evaluation process.

The tenderer is responsible for obtaining all information necessary for the preparation of the tender. The Council will not reimburse or be responsible for any costs incurred by tenderers in connection with the preparation or delivery or in the evaluation of the tender.

1.8 LINk Host tender

During the period of this tender, the Council will have issued an ITT for the provision of a Host service to the B&NES LINk.

The Council is unequivocal in stating that the provider of the B&NES LINk Host service will not receive any advantage whatsoever should they wish to tender for the supply of Healthwatch B&NES.

Similarly, any organisation which has been unsuccessful in their bid to provide the LINk Host service will in no way be disadvantaged should they wish to tender for the Healthwatch B&NES service.

All bids for all tenders advertised by the Council are assessed solely against the criteria stated in the ITT: performance in other tenders forms no part of the assessment process.

2 BACKGROUND

2.1 Function and Outputs

In its practical outputs Healthwatch B&NES will deliver 3 principle functions: Influencing, Signposting and Assisting. These functions are described in detail in the full specification below.

A top level summary of the **key early deliverables** expected includes:

- Achieving rapid credibility and embedded relationships with all relevant leaders and organisations in B&NES.

- Taking up HWB membership and establishing the best methods for members to cascade information in and out of the Healthwatch B&NES organisation.

- Quickly establishing a work programme that aligns to the Health and Wellbeing strategies, priorities and identifies how consumer voice can best contribute to this.

- Dynamically operating the established virtual social media and web based portal. Making this thrive and emphasising it as the primary channel of population engagement.

- Absorbing the health and wellbeing network- extending it and making it core to Healthwatch B&NES. Including in this the existing LINk membership, the patient participation groups in all GP practices, hospital members and all relevant community and third sector partners.

- Regularly summarise the findings of engagement activity and other intelligence provided by the community and support the development of the JSNA.

- Establishing the connections to local information and data sets that can signpost people to information about health and social care services and assist people.

2.2 Area Profile

Bath and North East Somerset is in the South West of England and has a population of approximately 178,000. About half of that number lives in the city of Bath, and the rest in the surrounding rural areas, villages and the towns

of Keynsham, Midsomer Norton and Radstock. Resident numbers are further enlarged by the student population attending universities and colleges in the area and in recent times there has been a significant rise in the number of migrants attracted to work in B&NES, especially from the Polish and Chinese communities.

Further information about the demographics of B&NES can be found here: http://www.bathnes.gov.uk/SiteCollectionDocuments/Education%20and%20Learning/EYFS%20Team/Equal%20Opps%20Folder%20Appendices%20for%20Web.pdf

http://www.swo.org.uk/local-profiles/banes/

http://www.thisisbath.co.uk/Revealed-rising-population-Bath-North-East/story-16543596-detail/story.html

http://www.improvinghealthandlives.org.uk/profiles/index.php?pdf=E06000022

The JSNA contains information about the service landscape of B&NES. It can be found here:
http://www.bathnes.gov.uk/communityandliving/ResearchAndIntelligence/Pages/default.aspx

2.3 Our Vision for Healthwatch B&NES

A dynamic and effective Local Healthwatch…

Healthwatch B&NES is here to make an impact. Operating as the consumer champion for health and social care in B&NES, Healthwatch B&NES will emerge as a prominent and influential partner in shaping and assuring local health and social care services. Through excellent professional relationships Healthwatch B&NES will interact with local leaders, commissioners and providers, contributing positively to improved wellbeing outcomes for the benefit of local people.

Through embracing the current engagement infrastructure and enhancing it year on year Healthwatch B&NES will achieve an engaging and dynamic organisation bringing the voices of consumers into the heart of decision making.

Healthwatch B&NES is expected to innovate and to feel different because of that; engagement, involvement and participation will be the heartbeat of Healthwatch B&NES. Social media, web based communications, the inclusion of patient participation groups, hospital groups, community and neighbourhood links, third sector engagement, localised outreach and active public dialogue will define the energy and approach of Healthwatch B&NES. In time the whole population will know about Healthwatch B&NES and will

witness the change as it brings together the disparate elements of involvement into a coordinated and powerful network.

The Health and Wellbeing Board (HWB) will be important to Healthwatch B&NES. Through its membership on the board Healthwatch B&NES will be enthusiastic and committed in its efforts to fully realise the opportunity of bringing the consumer voice directly into the setting of local plans and the delivery of local objectives. By constantly evaluating and summarising the public voice and bringing this forward, Healthwatch B&NES will continuously inform the Joint Strategic Needs Assessment (JSNA) that goes towards the identification of local priorities.

Within the contract parameters Healthwatch B&NES will achieve the ability to operate as an independent body under its own terms and at the same time set its own work programme to be in line with the priorities of the health and wellbeing strategy that it has helped to establish and that the commissioners and providers of services are also working to achieve. Operating in this way Healthwatch B&NES will be respected, and highly regarded. Partners will want to work with Healthwatch B&NES and will look to it to set and challenge the agenda as the authoritative voice of local consumers.

A social media shaped website linked to Twitter, Facebook and polling platforms is being established in advance of Healthwatch B&NES becoming operational. The Healthwatch B&NES provider will be expected to utilise and develop this approach.

…for everyone in B&NES

Healthwatch B&NES will be expected to work with all the key stakeholders and partners in B&NES. The following list is not exhaustive, but it is indicative of the range of people, groups and organisations that are key to the successful implementation of Healthwatch B&NES:

- Users of all adult and children's health and/or social care services within B&NES
- Carers of service users within B&NES (this may also incorporate the parents of children using services within B&NES)
- B&NES HWB
- Wellbeing Policy Development and Scrutiny Panel
- VCS
- Health and/or Social Care Commissioners
- Health and/or Social Care Service Providers
- B&NES Council's Children and Young Peoples Services
- Charitable organisations
- Residents and community groups
- Equality and diversity groups
- Clinical Commissioning Groups
- GPs, practice staff and patient groups
- Carers groups
- Groups/organisations representing people with Learning Difficulties

- Groups/organisations representing people with a physical or sensory impairment
- Patient Advice and Liaison Services (PALS)
- Councillors and MPs

2.4 Our vision for Healthwatch B&NES – Objectives

What we want to see happen

Local Healthwatch will build on and exceed the role of LINK through achieving, growing and sustaining an independent modern and proactive consumer voice for people. The aim of Healthwatch is to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided. It will be an effective and powerful local coordinator of engagement and assistance in all aspects of health and social care.

Healthwatch will:

a) Deliver three core operational functions: Influencing the planning and provision of health and social care, signposting people to information about health and social care services and enabling people to take issues forward with health and social care commissioners and providers.

b) Act as an involvement network working proactively to bring together and enhance the existing infrastructure of local engagement and support drawing input and participation from it and coordinating common outputs.

c) Implement powerful communications promoting an active, dynamic and ongoing public conversation through web and social media. Operating within the broader local engagement framework proactively outreach to communities utilising innovative and effective methods of communication that are inclusive and accessible to all groups.

d) Work successfully alongside partners achieving excellent professional relationships and working systems within which to present challenge to ensure the views and experiences of patients, carers and other service users are heard and taken into account with commissioners and providers.

e) Establish a common agenda of priorities within the framework of the health and social care strategy take up membership on the Health and Wellbeing Board and contribute a credible and proactive representation of the consumer voice within the Health and Wellbeing Board.

f) Ensure that the views and experiences of patients, carers and other service users are taken into account when local needs assessments

and strategies are prepared, such as the Joint Strategic Needs Assessment.

2.5 Alignment with Health & Wellbeing Board Priorities

Each Local Authority will establish a Health and Wellbeing Board covering health, public health and social care. Local Healthwatch will have a seat on the new statutory HWB, ensuring that the views and experiences of patients, carers and other service users are taken into account when local needs assessments and strategies are prepared, such as the JSNA and the authorisation of Clinical Commissioning Groups. This will ensure that local Healthwatch has a role in promoting public health, health improvements and in tackling health inequalities.

The Healthwatch provider will be expected to work in partnership with the H&WB to identify effective repersentation on the Board.

Healthwatch B&NES, being an independent body, will want to pursue issues raised by the community. In addition, and to maximise its impact, Healthwatch will be expected to align its core work programme to the priorities identified in the Health and Wellbeing Strategy, formulated by the HWB, and to focus its resources on those priorities.

Taking this approach will enable the consumer voice to be focused on the needs and priorities being addressed in B&NES and will more powerfully influence these outcomes for local people. Currently the priorities are:

- Improve outcomes for people who experience mental health problems
- Improve the outcomes of families experiencing complex needs
- Improve the outcomes of vulnerable groups
- Improve the outcomes of people with long term conditions (including end of life)
- Improve the outcomes of our aging population
- Reduce economic inequality (linked with poor outcomes)
- Develop healthy and sustainable places and communities

Health and Wellbeing engagement also extends beyond health and social care into the wider context of wellbeing, and Healthwatch B&NES will have the flexibility to contribute to this.

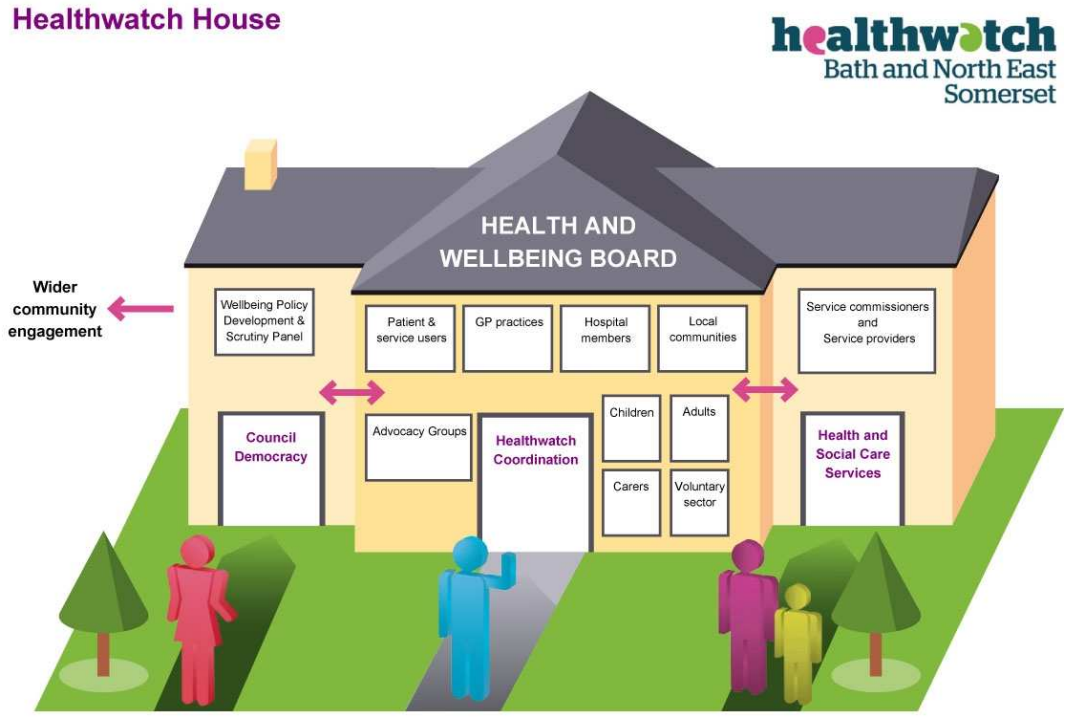
3 SPECIFICATION

3.1 The Principles of Healthwatch B&NES – Deliverables

What you will do to achieve the vision

Local Healthwatch will establish a well-recognised, open and common doorway through which citizens can interact with the health and social care

system. This is being described as the Healthwatch House, shown below. To achieve the full potential of this model Healthwatch B&NES will develop actions against six agreed principles of operation.



3.1.1 Establish and manage an effective organisation

Fulfil regulatory requirements

- Respond to final operational regulations.
- Deliver all existing LINk duties and new responsibilities as directed.

Operate an appropriate and proportionate organisation.

- Put in place a lean but effective core administration.
- Implement mechanisms for wider involvement.
- Implement mechanisms for an operating structure.

Promote an effective and inclusive brand.

- Ensure public recognition of role as champion of people using health and social care services.
- Ensure equal weighting for social care and health.

Quickly establish professional working relationships.

- Make relationships with all key commissioner and provider partners,
- proactively sustain these as ongoing and effective relationships.

3.1.2 Promote and communicate with the public

Demonstrate innovation of approach.

- 70% emphasis on internet communications and modern social media operating interactive and engaging portals for two-way communication and public participation.
- 30% emphasis on print and broadcast media and traditional methods ensuring appropriate mechanisms for all groups.

Actively publicise.

- Establish a promotion strategy and implement methods for continuous public communications to inform people on purpose, opportunities for public access and achievements.
- Work in collaboration with health and social care commissioners to promote self-care and the preventative message

3.1.3 Involve and engage all interested parties

Adults and Children.

- Bridge the gap between adults and children through liaising with existing infrastructures and identifying how messages can be coordinated where necessary and promoted individually where appropriate.

Act as a local network.

- Avoid duplication and maximise current capacities by co-ordinating and drawing together existing health and social care involvement structures, and operating within the broader local engagement framework.

Proactively reach out to all communities.

- Focus on reducing inequalities through targeting seldom heard and hard to reach groups
- Identify how to have a presence or access points in community venues
- Identify how to promote involvement in non-traditional venues
- Develop a strategy to reach those who are digitally excluded (i.e. do not have, or want, internet access)

Respond

- Provide advice to enquirers on where and how they can access information about services
- Deliver an effective process for service development impact assessments

3.1.4 Empower and enable workforce

Incorporate and build on the LINk's legacy

- Determine how to carry forward people and capacities from the existing LINk and continue to support selected streams of current work where advantageous to do so.

Establish effective volunteers and leaders.

- Organise how volunteers will be selected for key roles.

- Organise training and development of volunteers.

3.1.5 Perform and deliver

Justify public mandate.

- Articulate a confidence of aims and priorities.
- Be accountable and report on activity and achievements.

Maximise influencing opportunities

- Establish a strong role on the Health and Wellbeing Board, ensuring a large scope of influence on the commissioning agenda and decision making.

Work to a common agenda.

- Work within the priorities of the health and wellbeing strategy
  Identify how additional issues from the community will be progressed.

Advocacy

- Identify methods for advocacy and how group and individual issues will be pursued with local providers.

3.1.6 Develop and grow

Extend scope of involvement.

- Identify a vision for growth.

Extend and increase membership.

- Embed GP patient participation groups.
- Operate and develop the health and wellbeing network.
- Include foundation trust members and linkages into hospitals.
- Include linkages into social care providers.
- Include neighbourhood outlets such as parish and town councils.
- Increase public participation.

The result of this will be that Healthwatch B&NES will become:

- a strong local consumer voice on views and experiences to influence better health and social care outcomes
- a respected, authoritative, influential, credible and highly visible body within the health and social care community and on the HWB.

3.2 The outcomes for Healthwatch B&NES

What differences we will see

- Health and social care services are demonstrably influenced by the delivery of a strong consumer voice coordinated through Healthwatch leading to service developments that are influenced through the patient and service user experience.

- The impact of an influential independent body that champions quality and provides consumers with a strong voice is demonstrated through activity measures that show achievements and user satisfaction.
- Proactive and effective outreach is enabling wide involvement and participation by all sectors within the community who wish to be involved
- Greater participation from minority communities, seldom heard groups and children and young people is demonstrated.
- The consumer voice for health and social care is being effectively championed at Health and Wellbeing Board meetings, contributing to discussions on strategic priorities and influencing decision making.
- The opinions and experiences of local residents and service users are fairly and accurately recorded within the Joint Strategic Needs Assessment through Local Healthwatch feeding accurate and timely information into the process.
- The process for impact assessments and gaining the consumer perspective in service change is delivered in a timely and efficient way through a panel process or similar established by Healthwatch
- Local Healthwatch undertakes additional activities, subject to agreement, which assist the Health and Wellbeing Board in understanding the aspirations and wishes of residents and service users in respect of local health and social care services.
- B&NES Healthwatch is working collaboratively with the CQC, B&NES Council, Safeguarding Adults Team, and Childrens Social Work Teams to ensure a co-ordinated approach to “Enter and View” activities, and to enable maximum value for patients, service users and the general public.
- People in B&NES have easy access to the support, advice and information they need when making health and social care choices assisted through Local Healthwatch systems that coordinate and signpost to existing datasets.
- Local Healthwatch is well recognised as an effective and inclusive brand, championing health and social care issues.

3.3 The indicators of Healthwatch B&NES’ success

The following are proposed success criteria to be discussed and developed by the Council and Healthwatch:

- GP practice based patient participation groups are an integral part of Local Healthwatch, contacts are operating representation is in place.
- Healthwatch has reached out widely and deeply into the community and can show evidence of its effectiveness in this;
- Membership of Local Healthwatch has increased. The health and wellbeing network is continuously extended through coordinating key stakeholders including the third sector, advocacy groups, providers, the public and local communities to work together through Local Healthwatch

- The healthy conversation programme continues to develop as an effective brand including both physical and virtual methods of engagement.
- Consumer debate is enabled and encouraged through at least three Open Forum events which are organised and facilitated by Local Healthwatch and views and opinions are fed into the Health and Wellbeing Board.
- Robust and transparent governance arrangements are established achieving clear accountabilities and strong contract and performance management processes.
- Successful professional relationships are functioning with B&NES Health and Wellbeing Board, commissioner and provider leaders, Policy Development and Scrutiny panels, and third sector organisations;
- Local Healthwatch collates public / patient opinion and 'expert' community representatives contribute to Board discussions on specific issues.
- Local Healthwatch policy/strategy on equality and diversity and community engagement is in place being implemented and getting embedded;
- It has a growing evidence base of how people perceive the health and social care services they have received;
- It has identified areas in which health and social care services can be improved for users and potential users of services – and has made recommendations to the bodies responsible for those services;
- It has secured an agreed number of contacts in key areas such as GP practices, hospitals and social care service providers and these contacts are participating in Local Healthwatch;
- It is rated by key local organisations as a credible partner, scrutineer and holder to account;
- There is evidence of how Local Healthwatch has successfully influenced decision making / commissioning and has elevated the views of local residents through the JSNA, strategic decision making, commissioning process etc.

3.4 Contract monitoring requirements

- Healthwatch B&NES will report on its activities and finances to the Council on at least a three-monthly basis throughout the term of the agreement and more frequently and as reasonably specified as part of a performance management review process.
- Healthwatch B&NES's annual reports on expenditure, activity and achievements must be sent to the Department of Health.
- Healthwatch B&NES will be expected to report on its activities and on its financial position in relation to the contract with B&NES Council. All funds provided as a result of the contract awarded are to be spent on contract fulfilment. No funds may go towards any costs incurred which are not contract-related.

- Service reviews will also take into account feedback and recommendations from Healthwatch B&NES's governance arrangements.
- Meetings, the frequency of which will be agreed between the Council and Healthwatch B&NES, will be organised by the Council to review information gathered through the contract monitoring process, to review the specification. Representatives of Healthwatch B&NES's governance arrangements will be full partners in this process.
- Healthwatch B&NES will need to be able to demonstrate to the Council its performance against the contract by the fulfilment of key performance indicators.
- Healthwatch B&NES will also need to benchmark its performance against national quality indicators to be developed by the Department of Health.
- Healthwatch B&NES will be accountable to the Council. Healthwatch B&NES is required to undertake regular reviews or audits of its service and development plans.
- Healthwatch B&NES will be expected to contribute regular, scheduled inputs into the JSNA process.
- Healthwatch B&NES must have a written complaints procedure which should include a role for a person who is independent of the organisation, as either an investigator or decision-maker at an appeal stage.
- Where Healthwatch B&NES's own management reporting, stakeholder feedback, review process or other contract management activities reveal the need for remedial action, it must produce an action plan within one month of being formally notified by the Council, with a timetable to be agreed with the Council, outlining:
    - Detailed information on issues and associated risks
    - Appropriate solutions, including financial analysis
    - Responsible owners for all remedial actions required
    - Timescales for all remedial actions to be implemented
    - Monitoring arrangements to ensure remedial actions are completed

- Healthwatch B&NES should have its own internal quality assurance system, which should include standard setting, monitoring, management and review processes, to ensure the required service quality is maintained. Healthwatch B&NES will be required to confirm how improvement will be communicated on completion.

- Healthwatch B&NES must be a credible voice on the HWB, participating fully in discussion, influencing agenda planning and taking an active role in at least 4 meetings each year. It should attend all Board meetings, elevating patients' voices to the Board and effectively representing their views in a clear and evidenced manner. It should

contribute to Board discussion on strategic priorities and collate public / patient opinion as part of this. Healthwatch B&NES may also be asked to select expert community representatives to contribute to Board discussion on specific issues, subject to agreement. Healthwatch B&NES will also be a member of the steering group for the JSNA and the JHWS.

4 REQUIREMENTS OF THE SERVICE PROVIDER

4.1 Inclusion and Diversity

- Healthwatch B&NES must be inclusive and diverse in its make-up and will need to operate in different formats and methods of involvement and communication.
- Healthwatch B&NES must provide a service appropriate to people's needs and not shall discriminate on the grounds of their disability, race, culture, religion, faith or belief, sexual orientation, age, gender or socio-economic situation, in terms either of participation or of obtaining and representing people's views and experiences.
- Delivery of the services should be provided as closely to customers as possible through outreach, visiting etc. The expectation however is that 'back office' work will be provided through colocation and flexible working to reduce accommodation costs and provide the most flexible service possible to service users as well as synergy with other organisations This could include access to the Council's one-stop shop, 'landing sites' and other facilities as well as more localised delivery in local communities. All venues used will be required to be fully accessible. The delivery model will be expected to build for a green/low carbon future
- Healthwatch B&NES must comply with both the Data Protection Act 1998 and the Freedom of Information Act 2000 and ensure that Healthwatch B&NES participants are aware of their responsibilities under both of these Acts.
- Healthwatch B&NES must be committed to safeguarding and promoting the welfare of children and young people and expects all staff and volunteers to share this commitment, and to be effectively trained in all aspects of safeguarding legislation and practice.

4.2. Governance Structure

The Regulations governing Local Healthwatch stipulate that there must be a strong involvement by volunteers and lay members, including its governance and leadership. The provider of Healthwatch B&NES must therefore demonstrate the centrality of volunteers in its governance and leadership.

On that basis, Healthwatch B&NES will be expected to structure itself according to the following:

- will be a body corporate and be able to meet the criteria of a social enterprise;
- establish a panel of Authorised Representatives to exercise the statutory Healthwatch B&NES function of entering and viewing specified health and social care premises;
- ensuring that such persons are receiving appropriate training and Criminal Records Bureau clearance in line with relevant policy guidance;
- effective organisation of meetings, giving at least 5 clear working days' notice of meetings, making appropriate arrangements for those able to attend, and recording, making available and communicating the outcomes, agreements and actions of all meetings;
- maintenance of a record of meetings convened including a breakdown of attendance/attendees/representation;
- statutory consultation deadlines met and copies of reports are made available;
- Healthwatch B&NES and the relevant Council Policy Development and Scrutiny panels develop an ongoing working relationship;
- Healthwatch B&NES members are aware of and have the opportunity to attend Board meetings of NHS bodies in their area and/or have the opportunity to meet Non-Executive Directors of trusts and PCT's;
- Healthwatch B&NES is able to convey its views to health and social care commissioners and providers, and through the relevant Policy Development and Scrutiny panels;
- Healthwatch B&NES is a credible voice on the HWB, influencing plans and policy decisions;
- user representatives on strategy and planning teams are appropriately briefed and supported and able to contribute effectively;
- audit and accounting requirements (including reporting) are met;
- complaints are investigated according to the complaints policy;
- hold a minimum of 6 public meetings each calendar year, at times and places which take into account the circumstances of different sections of the local community (e.g. those who have limited access to public transport; those who are in full-time employment; those who are carers). It is therefore expected that some public meetings will be held at evenings and/or weekends.

4.3 Heathwatch B&NES Delivery Models

Following are some models for the delivery of Healthwatch B&NES. We do not have a preference for the model used, and we are open to receive bids using organisational arrangements other than those shown below. However, if more than one organisation is involved in a bid, this should be explained

clearly in the response to the tender, and only the Lead Organisation should be involved in submitting a bid:

- Single supplier – all Healthwatch B&NES services delivered by a single organisation;
- Sub-contractor – the supplier sub-contracts some or all of its services to other suppliers;
- Consortia – two or more organisations work in a formal or informal arrangement to deliver Healthwatch B&NES services

4.4 TUPE

Please note: Until 19th October 2012 the LINk Host service was provided by an external contractor, Scout Enterprises Ltd. On that date Scout Enterprises Ltd went into liquidation.

Employee information received from Scout Enterprises concerning the three members of their staff who delivered the B&NES LINk Host service is contained in Appendix 4. Tenderers should note that the Council is not able to guarantee the accuracy of the information and will not accept any liability as to its accuracy. Tenderers are advised to seek independent professional advice on the application of TUPE: the Council is not able to offer advice to bidders on TUPE issues.

APPENDIX 1 – Contract value

The funding confirmed so far for this contract is £246,000 for the life of the contract, 1st April 2013 – 31st March 2016.

This information will be updated via ProContract should there be any changes to confirmed funding levels.

Healthwatch B&NES will be accountable to the Council and the public to demonstrate effective spend of its budget.

If any further funding for Healthwatch B&NES is confirmed during the lifetime of the contract, the Council will agree with the service provider how this funding is to be used to deliver the service described in this specification.

APPENDIX 2 - Criteria and scoring method for tender responses

1. Organisational requirements

An organisation will only be considered for this contract if:

1.1 it conforms to the requirements of the Health and Social Care Act 2012 section 183 and any and all subsequent Regulations issued by the Department of Health in respect of providers of Local Healthwatch services;
1.2 its total budget for the provision of Healthwatch B&NES does not exceed the amount stated in Appendix 1 above, unless notification of an amended sum is issued to bidders through ProContract;
1.3 it submits the documents listed in Criteria 1. below;
1.4 a financial appraisal by competent Council officers indicates that the organisation has the financial strength to successfully deliver the contract – see Appendix 3
1.5 the sum quoted in 4. below does not exceed that stated in Appendix 1 above.

2. Criteria and scores for tender responses

A Fail for criteria 1 or 2 below will result in the bid being excluded from the assessment process.

You are required to provide a written response to each of sections 3.1 – 3.7 and 4. And 5. below. Do not amalgamate responses to two or more sections into a single response. Each response will be scored as shown.

We would prefer you to use Arial 12 point black for your responses. All responses must be in English.

Please do not include hyperlinks, attachments or any other material in your responses (except for the responses to Criteria 1. and 3.7 below), as they will not be taken into consideration.

Criteria	Weighting
1. Provide hard or soft copies of the following documents from your organisation, which should be current at the time they are submitted: • **Safeguarding policy** • **Health and safety policy** • **Sustainability policy** • **Equal opportunities policy** • **Public liability insurance certificate**	**Failure to provide one or more of these documents will result in a Fail**
2. Financial appraisal – see Appendix 3	**Pass/Fail**
3. Taking into account the vision for Healthwatch B&NES described within the specification document, demonstrate how you will deliver that vision in the following ways:	

3.1 What you will do to achieve and constantly maintain inclusive, accessible and effective engagement of the whole of the B&NES community; Response (200 words maximum):	9%
3.2 What you will do differently to ensure impact and constant involvement through innovative and modern communications; Response (200 words maximum):	9%
3.3 What you will do to achieve and ensure highly effective relationships with leaders, decision makers and partners; Response (200 words maximum):	6%
3.4 What impact your delivery of Healthwatch will make on the health and social care provision in B&NES; Response (200 words maximum):	9%
3.5 How you will measure the success of your strategy and operational plan; Response (200 words maximum):	9%
3.6 How you will maximise the opportunities of Health and Wellbeing Board membership and the alignment of Healthwatch activity to the Health and Wellbeing Board strategic priorities; Response (400 words maximum):	8%
3.7 Provide a detailed three-year implementation plan with a detailed budget showing how you will deliver the expectations described in the specification. Response (600 words maximum – you may also include diagrams and other illustrative material in this response):	20%
Sections 3.1 – 3.7 above will each be scored as follows:	
Excellent standard of response; exceeds the requirements in a number of areas and is supported by strong evidence which gives the Council a high level of confidence.	8 - 10
Competent standard of response; meets requirements and is supported by a satisfactory level of evidence although there are a few issues which give the Council cause for some minor concerns.	4 - 7
Inadequate response; fails to meet some requirements and is generally unsatisfactory and/or has omissions and/or is not supported by evidence. Gives the Council cause for serious concern.	1 - 3
No response provided and/or substantial omissions which make the response fundamentally unacceptable and give the Council cause for major concern.	0
The total marks awarded for sections 3.1 – 3.7 will comprise 70% of the overall score.	
4. Please state the total cost to the Council, excluding VAT, for	30% of

supplying this service over the full period of the contract:	overall score
5. Please state your Company Number:	

3. Overall scoring

Responses will be evaluated on the following quality/cost ratio:
Quality (Criteria 3.1 – 3.7 above) 70%
Cost (Criterion 4 above) 30%

The preferred supplier will be the organisation with the highest overall combined score.

APPENDIX 3 - Financial evaluation method

The key objective of financial appraisal is to analyse an applicant's financial position and determine the risk that it would represent to the Authority. A range of factors needs to be considered as part of the appraisal and various financial statistics, ratios and figures analysed. Once the appropriate data has been obtained a professional judgement must then be applied to the issues.

When undertaking the financial vetting the Authority looks at the tenderers most recent accounts along with those of any ultimate parent company (if applicable). These would be checked for general audit issues and then analysed to give an indication of profitability, liquidity, net worth, asset/debt position, capacity and general stability.

The Authority recognises that the accounts submitted often relate to an accounting period that finished several months earlier. Where appropriate it will consider other information that it considers reasonable to use in determining the risk represented by a bidder.

The Authority will also consider any additional information submitted by the applicant should the applicant consider this necessary for the Authority to have a fuller understanding of its financial position. This may be appropriate, for example, to obtain a fuller understanding of an applicant's financial structure or funding arrangements. The Authority would expect any such information to be verified by an independent source, for example, the applicant's auditors.

Initially basic checks are made on a bidder's title and any relevant registration details (e.g. registered number at Companies House). The Authority would check whether the bidder is trading or dormant and whether it has a parent company. The status of the accounts is also determined to check whether accounts submitted are for the last accounting period for which statements have been filed and whether there are later accounts that are overdue.

When considering profitability the Authority looks at the gross profit margin and operating profit margin. These ratios indicate the efficiency of the organisation. A loss in the year would be looked at in conjunction with the balance sheet resources available to cover this loss.

When looking at liquidity the Authority uses the current ratio and the acid test ratio. The current ratio is a measure of financial strength and addresses the question of whether the bidder has enough current assets to meet the payment schedule of its current debts with a margin of safety for possible losses in current assets. The Acid Test ratio measures liquidity and excludes stock to just really include liquid assets.

The Authority would look at the bidder's balance sheet and determine the net worth of the organisation and that element that can be mobilised in a financial

crisis. The Authority would look at the net assets and also the net tangible worth (excluding intangible assets). The Authority would also look at the proportion of total debts against total assets.

Contract limit is the size of contract that is considered ‘safe’ to award to a bidder, based on a simple comparison of the annual contract value to the annual turnover of the organisation. This gives the Authority an idea of financial strength to ensure that the bidder can cope financially with this size of contract. The Authority assesses the capacity issue of whether the bidder has the resources to carry out the work.

The Authority would consider all of the above in relation to the bidder and that of any ultimate parent company and then a judgment would be made as to the risk that the organisation would represent to the Authority. The final decision regarding the acceptability of the bidder’s financial standing relies on a degree of professional judgment from the Authority. If the Authority decides that the financial standing of the bidder represents an unacceptable risk to the Authority then the bidder will be excluded from further consideration in this process.

APPENDIX 4 – B&NES LINk Host: Employee Information (see 4.4 above)

Employer	M/F	Contract	Job Title	Location	Type of Contract	Weekly Contracted Hours of Work
Scout Enterprises Ltd	M	B&NES Link	Contract Manager	Bath	Standard	18.5
Scout Enterprises Ltd	F	B&NES Link	Administrator	Bath	Standard	25
Scout Enterprises Ltd	F	B&NES Link	Co-ordinator /Development Worker	Bath	Standard	18.5

Annual Gross Salary	Additional Notes	Employment Start Date	**Age:** Note please do not enter date of birth	Does the employee currently work for, or have they ever worked for the civil service or other public sector employers (under the meaning of the Cabinet Office guidance on fair deal for staff pensions?)	Remarks	Holiday entitlement (excluding national holidays)	This year	Remaining
£28,876.00 (37 hours per week)	None	24.11.2003	63	Yes	Early retirement from NHS following redundancy	23	23	23
£11,452.00	None	12.10.2009	47	No	None	21	21	12
£11,337.00	None	06.10.2008	46	No	None	13	13	13

Booked	Disciplinary/ grievance	Court/ Tribunal	Sickness (2 years)	CRB Status	Right to Work
0	None	None	0	Yes	Yes
4	None	None	8	No	Yes
0	None	None	4	Yes	Yes

Job Title: **Administrator**

Responsible to**: LINk Co-Ordinator/Development Worker**

Base: Bath

Hours: 25 per week

Job Summary: The post holder will be responsible for the provision of effective administrative support to the LINk Co-Ordinator/Development Worker and Contract Manager working with the Bath & North East Somerset LINk.

Main Responsibilities:

1. Establish and maintain administrative systems which support the effective operation of the LINk.
2. Ensure effective use of IT systems to store and disseminate relevant information.
3. Maintain database of information for all LINk, members, participants and contacts
4. Co-ordinate diaries of staff and take responsibility for the organisation of LINk meetings
5. Maintain list of LINk meeting venues and room bookings.
6. Take notes/minutes of meetings when requested to ensure accurate notes/minutes/letters/emails are sent out appropriately.
7. Support liaison between Host staff and LINk participants.
8. Act as a contact point for all enquiries/requests from LINk members and the public either by telephone, email or face-to-face, and deal with accordingly during agreed office hours.
9. Prioritise workload to ensure deadlines are met.
10. Support LINk meetings in the absence of the Development Worker or Contract Manager in B&NES.
11. General office duties, to include photocopying, filing, post, distribution log and any other duties commensurate with the post.
12. Involvement in producing newsletters, LINk publicity materials and bulk mailouts.
13. Operate within Data Protection Legislation and LINk Confidentiality Policy
14. Undertake other duties appropriate to the post as directed.

Job Description

Job Title: **LINk Co-Ordinator/Development Worker**

Responsible to**: Contract Manager**

Base: Bath

Hours: 18.5 per week

Job Summary:

The post holder will be responsible for the promotion of the LINk to people and organisations throughout Bath and North East Somerset, and for the recruitment and development of Members of the LINk. He/she will also assist the LINk in the understanding of health and social care issues and the development and carrying out of its work programme.

The post holder will also be responsible for co-ordinating the LINk's work plan and to ensure provision of effective administrative support for BANES LINk.

Main Responsibilities:

- to support involvement and consultation with residents of Bath & North East Somerset for the purposes of developing and promoting the LINk.
- to recruit individuals and groups to participate in the LINk, and to develop and maintain public awareness of the LINk and its activities.
- to carry out all work with close attention to equalities and accessibility issues, and to promote diversity in the LINk membership, work and public engagement.
- to ensure a representative spread of involvement and the involvement of traditionally "hard-to reach" groups within the community through "outreach" work and other innovative techniques of engagement.
- to identify training and development needs of LINk Members, and to develop ways of meeting these needs.
- to work with the LINk members and the Host team to identify realistic objectives in respect of workplan projects, and to assist with the prioritisation of this work.
- to research background information as necessary, and gather information to inform projects and LINk activities.
- to assist the Contract Manager in the support and monitoring of LINk project work.
- to work with the Contract Manager to develop engagement tools (including questionnaires for surveys). and to collate, analyse and interpret data and the findings from the LINk's work.
- with the assistance of the Administrator, to organise meetings and events on behalf of the LINk, such as LINk workshops and public health initiatives.
- to develop good working relationships with the relevant NHS Trusts, B&NES Primary Care Trust, Bath & North East Somerset Council and the statutory regulators of health and social care, as well as other appropriate statutory and

voluntary agencies and groups.

- to develop and maintain own knowledge base on national and local health and social care issues and activities.
- to assist in the research for and production of newsletters, bulletins, and other information, and to develop the LINk's marketing and publicity materials (including leaflets and posters).
- to work with the LINk team in the production and delivery of public presentations on the LINk and its work.
- to help the LINk to increase understanding and knowledge of local health and social care issues.
- to ensure effective use of IT systems to disseminate relevant information, and to make a major contribution to the promotion, monitoring and updating of the LINk web site.
- to identify and develop public involvement opportunities on behalf of the LINk.
- to undertake other duties related to the LINk as necessary or at the direction of the Contract Manager.
- Provide line Management for the LINk Administrator and Assistant Development Worker, to ensure effective Administration is provided for the LINk contract.
- Set up office systems and ensure effective use of IT for storing and disseminating relevant information, including record keeping and maintaining database of information for all LINk contacts
- Prioritise workload to ensure that own and team deadlines are met.
- Operate within Data Protection Legislation and LINk Confidentiality Policy

Job Description

Job Title B&NES LINk Contract Manager

Location: Bath

Hours: 18.5 per week

Main Purpose of Job:

To provide the strategic lead function for the B&NES LINks, including management of staff, work planning and service delivery.

Reporting Structure:

You report to:	Divisional Manager
Those that report to you:	LINk staff and volunteers of LINk

Key Tasks and Responsibilities:

Management:

- To be responsible for planning and implementing the work of the LINk team in line with the requirements of the organisation, contract manager and the LINk governance structures;
- To develop and ensure the implementation of processes, protocols, policies and partnership agreements as required by the LINk membership;
- To develop and support the governance arrangements for the LINk;
- To be responsible for monitoring and reporting against the operational plan for the LINk, reporting to the governance structures as agreed;
- To manage the process of mapping engagement activities and developing engagement mechanisms to meet the LINk needs;
- To develop and manage a communications strategy and implement information sharing processes.

Strategic Work:

- To develop and support the LINk to have a high profile within the community and amongst service providers;
- To develop strategic relationships with statutory and VCS partners;
- To liaise with appropriate individuals and organisations such as NHS bodies, Councils, Overview and Scrutiny Committee and strategic partnerships;
- Support the LINk to implement transparent and accountable work practices
  e.g. overseeing the governance structures, managing membership, dealing with complaints and ensuring standards are met;
- To promote the work of the LINk throughout the area, and to encourage engagement from all sections of the community;
- To effect relationships through partnership building with senior strategic managers in the statutory sector;

- To liaise with partners to effect change in organisations and service delivery;
- To attend diverse partnerships and forums to promote the work of the LINk;
- To work with a diverse range of stakeholders, to manage conflict and competing interests;
- To complete presentations and reports to a variety of audiences.

Financial:

- To manage the budget for the LINk in line with organisational policy and contractual obligations;
- To work with the management team and LINk governance structure to review and plan expenditure;
- To complete reports and monitoring information as required.

General:

- To be responsible for the day to day management and supervision of the LINk support staff;
- Develop and oversee a volunteer recruitment and support programme and ensure staff/volunteers are supported and appropriate training available;
- Ensure there is adequate induction and support for staff, LINk members, the network itself and volunteers;
- To work with volunteers and empower all members of the community to engage with the LINk;
- To analyse complex information and be informed by relevant legislation and specific guidance in relation to LINk;
- To produce quality written reports, presenting accessible information to a diverse audience;
- To work to combat all forms of discrimination, and to ensure that the principles of equal opportunities are implemented in all work undertaken on behalf of the Company and LINk;
- To work as a member of management team adhering to all policies and procedures, and to contribute to the development of policy and good practice within the Company;
- To work flexible work patterns if necessary in response to the needs of the LINk membership and other partners. This may include weekend and evening working;
- To carry out the above duties, and any other duties commensurate with the responsibilities of the post which may reasonably be required, in a manner which actively supports and promotes Company's aims and policies;

APPENDIX 5 - Abbreviations and Definitions used in this document

The following abbreviations and terms are used throughout this document:

B&NES -	Bath & North East Somerset
(The) Council -	Bath & North East Somerset Council
CQC -	Care Quality Commission
Healthwatch B&NES -	Healthwatch B&NES always refers to the B&NES Local Healthwatch unless stated otherwise
HWB -	Health and Wellbeing Board
ITT -	Invitation to Tender
JHWS -	Joint Health and Wellbeing Strategy
JSNA -	Joint Strategic Needs Assessment
LINk -	Local Involvement Network
NHS -	National Health Service
PALS -	Patient Advice and Liaison Service
PCT -	Primary Care Trust
Social Enterprise -	A body is a social enterprise if it is a 'business with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community'. (Department of Health). No restriction is imposed on the nature of the incorporation (e.g. it might be a Company Limited by Guarantee, Community Interest Company, Industrial and Provident Society, etc.).
TUPE -	Transfer of Undertakings (Protection of Employment)
VCS -	Voluntary and Community Sector

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Bath and North East Somerset (B&NES) Health and Social Services Overview & Scrutiny Panel
Briefing FOR INFORMATION
Potential Re-provision of RNHRD Neuro-Rehabilitation Service

NHS
South of England Specialised Commissioning Group
NHS
Bath and North East Somerset

PART 1

Re: Provision of Neuro-Rehabilitation at the Royal National Hospital for Rheumatic Diseases OSC Briefing: For Information & Comment

PCT Sponsoring Director/s:	Jennifer Howell, Interim CEO, NHS Bath and North East Somerset (B&NES) Dominic Tkaczyk, Interim Director of Finance, NHS B&NES Tracey Cox, Associate Director of Commissioning NHS B&NES & Chief Operating Officer (designate), B&NES C.C.G. Craig MacFarlane, Communications & Engagement Lead, NHS B&NES Corinne Edwards, Associated Director for Unplanned Care & Long Term Conditions, NHS B&NES
Specialised Commissioning Team:	Sue Davies, Acting Director of Commissioning, South of England Specialised Commissioning Group, South West Team Esther Giles, Acting Director of Finance, South of England Specialised Commissioning Group, South West Team Arthur Ling, Lead Commissioner for Specialised Neuro-Rehabilitation Services, South of England Specialised Commissioning Group, South West Team Lou Farbus, Head of Public & Patient Engagement, South of England Specialised Commissioning Group, South West Team

1 Purpose of the Report

1.1 To report to the Bath and North East Somerset (B&NES) Health and Social Services Overview & Scrutiny Panel:

- the proposed re-provision of **specialised** neuro-rehabilitation services (inpatient and outpatient) provided at the Royal National Hospital for Rheumatic Diseases (RNHRD's) from April 1st 2013;
- that additional capacity for the provision of level 1/2A neuro-rehabilitation has been identified and agreed in principle with two alternative providers at Level 1 and a wider range of providers at Level 2A to ensure continuous provision from 1st April should scrutiny vote to support this interim re-provision proposal;
- that a programme of stakeholder (patients, carers, public, RNHRD staff and providers) engagement on the short- and long-term provision of neuro-rehabilitation in the South West has been carried out, with due regard given to two extensive reviews of local services recently carried out by Somerset and Devon Local Involvement Networks.

(This paper should be read in conjunction with the Bath & North East Somerset Primary Care Trust's briefing on the re-provision of the non-specialised Outpatient Neuro-rehabilitation service).

2 Decisions / Actions Requested

2.1 The B&NES Health and Social Services Overview & Scrutiny Panel is asked to :

- note that patients from the South West have and will continue to receive the best quality neuro-rehabilitation services that the NHS is able to provide;
- note there have been no issues regarding quality or safety in the RNHRD's decision to cease providing neuro-rehabilitation after the 31st March 2013;
- note the continued high level of quality care and family experience that the recommendations are able to support;
- note commissioners' collaboration with key stakeholders, including patients and the public as well as potential providers, in developing the recommended re-provision option;
- note that proposals should maintain the existing high quality of care without any adverse effect on current in-patients or future access to the service;
- support the proposal for service re-provision in the proposed centres.

3 Background to Neuro-rehabilitation Services

3.1 The Royal National Hospital for Rheumatic Diseases (RNHRD) in Bath specialises in Rheumatology, Neurological Rehabilitation, Fatigue Management and Chronic Pain. As the smallest Foundation Trust in the country it is currently addressing significant financial challenges. It therefore needs to consider carefully the future of any service where patient referrals are reducing.

3.2 The neuro-rehabilitation service provides care for patients requiring either specialised or non–specialised (less complex) care. Specialised rehabilitation is the total active care of patients with a disabling neurological condition, and their families, by a multi-professional team who have undergone recognised specialist training in rehabilitation, led/supported by a consultant trained and accredited in rehabilitation medicine (RM) or neuropsychiatry in the case of cognitive / behavioural rehabilitation.

3.3 Services are identified on the basis of complexity of their caseload.

3.4 Generally, the severity of the condition is broken down into different categories as follows:

- Four categories of rehabilitation need (categories A to D)
- Three different levels of service provision

3.5 Following brain injury or other disabling conditions:

- The majority of patients have category C or D needs and will progress satisfactorily down the care pathway with the help of their local non-specialist rehabilitation services (Level 3).

- Some patients with more complex needs (category B) may require referral to local specialist rehabilitation services (Level 2b).
- A small number of patients with highly complex needs (category A) will require the support of tertiary 'specialised' services (Level 1/2A).

3.6 'Tertiary specialist' rehabilitation services (Level 1/2A) are high cost/low volume services which provide for patients with highly complex rehabilitation needs following illness or injury, that are beyond the scope of their local general and specialist services. These are normally provided in co-ordinated service networks planned over a regional population of 1 to 3 million through collaborative (specialised) commissioning arrangements.

3.7 Levels 2b-d are not specialised services and are therefore currently commissioned by Primary Care Trusts. Level 1 and 2A services are specialised and are the only levels of care that are currently commissioned by specialised commissioning groups. From 1 April 2013 Level 1 and 2A services will be commissioned by the NHS Commissioning Board and non-specialised aspects of the service will be commissioned by Clinical Commissioning Groups (CCGs).

3.8 RNHRD has experienced a steady decline in patient numbers over the last few years, with patients from outside the area particularly, being treated closer to where they live. There have also been new pathways for some of the non–specialised patients. These are appropriate and reflect ongoing changes in the way care is delivered.

3.9 Recognising that specialised services can be subject to fluctuating levels of demand the South West Specialised Commissioning Team's (SWSCT) contract for 2012-3 for inpatient neuro-rehabilitation activity at the RNHRD has been agreed as a 'block with a collar and cap arrangement'. This simply means that commissioners have tried to ensure a reasonably consistent level of income for the provider such that, it receives additional income if over 11 beds are used, but does not have to refund income if only 9 beds are used. However if less than 9 beds are used, the Trust would not receive the full level of income.

3.10 The table below shows that whilst the trend of reducing patient numbers is not the case for specialised patients, the numbers of these patients in any year across the South West and for individual PCTs is low. The overall change in demand when non-specialised referrals are taken into consideration however has meant that the income for the service has reduced by almost 50% over this period. The service went from a peak in August 2010 when the unit provided 578 occupied bed days to August 2012 when activity had reduced to 192 occupied bed days. This has led to the service becoming financially unsustainable and the Trust's decision at the end of December 2012 to cease providing the service after March 2013.

PCT Population	2009-10	2010-11	2011-12	2012-13
Bath & North East Somerset	13	20	20	12
Bournemouth & Poole	0	1	0	0
North Somerset	2	0	1	0
South Gloucestershire	3	1	2	2
Swindon	3	0	0	0
Bristol	2	1	1	1
Cornwall & Isles of Scilly	0	0	1	0
Devon	1	0	0	3
Dorset	0	1	0	0
Gloucestershire	0	0	3	1
Somerset	1	2	4	3
Wiltshire	6	4	2	7
Hampshire	16	13	9	1
All other PCTs	8	5	6	0
Grand total	55	48	49	30

N.B. The table shows the number of patients requiring specialised care over the last 3.5 years because the figures for 2012/13 are for 6 months only.

4 Re-provision

4.1 Since the RNHRD announced its final decision at the end of December the SWSCT have met with the neuro-rehab team at the RNHRD to discuss:

- In the short term, what aspects would be needed in service re-provision. This focused on Levels 1 and 2A (specialised) care only.
- What aspects of the current service staff feel add value.
- In the medium and long term, what aspects of the service would current staff like to see incorporated in a future commissioning plan.

4.2 Looking at annual usage and lengths of stay, the SWSCT identified that it would require 8-9 beds per annum with a split as follows:

- 6-7 Level 1
- 1-2 Level 2

In addition approximately 30-40 patients per annum will need outpatient follow up care following their inpatient admission.

4.3 There are only a few providers in the region able to provide Level 1and 2A care either owing to the complexity of care required and an inability to provide the standards

required for 1and 2A care or lack of capacity to be able to receive additional patients. However, after a series of discussions with various providers of specialised neuro-rehabilitation the following arrangements have now been agreed in principle

4.4 There is provisional agreement from April for the following Level 1 care:

- an additional 2 beds to be provided at Frenchay's Brain Injury Rehabilitation Centre (BIRC) with an additional 3 beds coming available following some building alterations by the end of June 2013. (The BIRC is currently a 24 bedded unit.)
- 2 additional beds at Oxford Centre for Enablement (OCE), from April with the potential to increase to 3 if required. The OCE is a 26 bedded unit currently.

Both of these services will provide follow up outpatient care to any patients admitted.

4.5 There has also been a review of providers which provide level 2A care. There is a wider number of providers which provide this level of care and it has been identified that several of these have capacity .Where appropriate, patients requiring this level of complexity would thus be referred to the most local geographic service. These services are:

- The Plym Rehabilitation Centre, Plymouth
- Rehabilitation unit at Taunton and Somerset NHS Trust
- Glenside
- The Dean Neurological Centre, Gloucestershire
- Swindon BIRT (opening May 2013)
- Rehabilitation unit, Poole General Hospital

4.6 Admissions to the RNHRD have been reviewed over the last two months to ensure that any patients admitted were likely to be discharged by the end of March 2013, to avoid disruption to their inpatient care. This is being closely monitored and it is anticipated that all current inpatients will be discharged by the end of March. Were there to be any change in their condition arrangements will be made to transfer them to BIRC or OCE as appropriate.

A review of all outpatients has also been carried out by the RNHRD clinical team and those requiring further specialised outpatient treatment following a recent inpatient admission will be referred on to BIRC or OCE (or a more local neuro-rehabilitation service if recommended).

5 Local Impact Assessment

5.1 The potential impact of the service change was also considered. For example, the average times/distances (see table below) was calculated by looking at the post code of residence for all inpatients admitted to the RNHRD during the calendar year 2012 and then averaging the journey time to each of the providers by public transport and car.

Averages	Leaving 0900 11/12/2013	Public Transport (minutes)	Car (minutes)	Distance (miles)
RNHRD	BA11RL	64.00	33.67	19.28
BIRC	BS161UU	106.98	41.49	26.27
OCE	OX37HE	174.16	108.84	89.12

- One patient would have had a shorter journey if travelling to the OCE rather than the RNHRD.
- One patient would have less miles to travel if they were to travel to the OCE rather than the RNHRD.
- 12 patients would have less miles to travel if they were to travel to BIRC rather than the RNHRD.
- 14 patients would have had a shorter journey if travelling to the BIRC rather than the RNHRD.
- 31 patients would have had more miles to travel if they were to travel to BIRC rather than the RNHRD.
- 29 patients would have had a longer journey if travelling to the BIRC rather than the RNHRD.

5.2 This shows that the greatest impact in terms of travel is likely to be on families who do not receive a means tested benefit who are visiting people receiving inpatient care and patients receiving outpatient care at OCE. However, only a small proportion of the people from BaNES that may access this service each year are likely to be referred to OCE. In addition, a significant proportion of patients will have less far to travel to BIRC. Moreover, many of those travelling to attend out-patient appointments would also be eligible for support with transport costs either through hospital transport services (such as hospital car or ambulance) or the financial support set out in the Department of Health guidance ‘HC11 – Help with NHS Costs’.

5.3 In terms of the potential impact on ‘protected’ groups, we found no difference in the ability of the current and proposed providers to meet the needs of different patient groups as each patient receiving neuro-rehabilitation is an individual, with very specific needs that require a service that is sufficiently flexible to be able to meet those needs. Consequently, those who deliver neuro-rehabilitation are particularly experienced and skilled in adapting to accommodate the challenges in verbal and written speech and language, mobility, cognition, culture, mood and behaviour that their patients experience. Similarly, every NHS contract (Section B. 14.2.3.) requires all NHS services to provide assurance of how it will meet its equality duties. This supports services to be commissioned, provided and contractually monitored so that they meet the needs of all patients and local communities.

6 Stakeholder Engagement

6.1 As previously stated, the SWSCT met current staff at RNHRD to take their views on the features which were most important for securing service excellence. Here, staff stressed the importance of providing care that was based on best, evidence-based practice, highlighting the importance of staff training and development. Equally, the best neuro-rehabilitation services have multi-disciplinary (having the right range of experts) and inter-disciplinary (mutual respect and understanding of each discipline's expertise) teams that are highly experienced. These teams take a holistic approach by providing facilities for families such as counselling, accommodation for loved ones to stay whilst visiting inpatients and support to prepare families for patients returning home. Facilitating good working relationships with community-based services was also said to important to ensure patients had the greatest chance of a successful discharge.

6.2 This information was used to identify available specialised level 1/2A care that most closely matched the excellent service provided at RNHRD in an attempt to ensure continuity in patient care and family support.

6.3 Specialised and PCT commissioners then worked with an expert patient to jointly develop a programme of public and patient engagement designed around the options for re-provision and targeted at the populations most affected by any potential change in the location of the service. Hence, two public and patient engagement events were held. One at the RNHRD in Bath to make it easier for affected patients and families to attend and one in Taunton, the geographical centre of the South West, for people who lived further afield.

6.4 All information and materials used in relation to the neuro-rehabilitation engagement programme can be viewed at http://www.swscg.org.uk/consultation/ New information will be posted here as it becomes available. For example, stenographers were present at each of the events so that verbatim transcripts of what was said could be made available for people who were unable to attend and people with speech difficulties. The transcripts will be posted on the website soon as the SWSCT receive them.

6.5 At each event commissioners outlined the work carried out and the proposed re-provision options. Lead consultants from BIRC and OCE attended one event each to answer people's questions about the services they deliver and to hear first hand what people said was important to them. The questions that commissioners asked delegates included questions submitted by overview and scrutiny and local involvement network members.

6.6 In total 51 different people attended at least one of the events. Approximately half of these had received neuro-rehabilitation either as a patient or as the loved one of a patient; the rest were professionals who work in neuro-rehabilitation in some way, scrutiny councillors, local involvement network colleagues, or PCT commissioners from across the region. The information they provided was added to information from completed questionnaires. The questionnaire was, and still is, available on the internet (http://www.swscg.org.uk/consultation/). This will remain there until the end of March and any new data added to the final Engagement Report that will be submitted to the National Health Service Commissioning Board (NHS CB) and Clinical Commissioning

Groups (CCGs) that (respectively) take over commissioning the specialised and non-specialised aspects of the service from 1st April 2013.

6.7 In addition to telling commissioners what aspects of the service they regarded as most important, people were encouraged to question the panel. A summary of the questions people asked and the answers that were given is available in Appendix B.

6.8 It would be wrong to provide a summary of the things people said they would want from a new service without acknowledging that the RNHRD's neuro-rehabilitation service and its staff were universally praised and people would prefer for it to continue. Nevertheless it was acknowledged that the repatriation of out of region patients had reduced activity at the service to such an extent that it was no longer sustainable.

6.9 In telling commissioners what the most important aspects of a quality neuro-rehabilitation service were, the following themes were identified.

Staff

- A highly trained and experienced multi-disciplinary team
- Continuity of care from the same multi-disciplinary team throughout the pathway
- Active in research and development
- Good communication between all members of the care team, community based colleagues, patients and families

Holistic Care

- A wide range of therapies available
- Support and facilities for carers
- Access to latest treatments and research studies
- Bespoke care that is needs led
- Regular follow-ups
- Self-referral back into the service after discharge
- Access to community-based interventions/3rd sector support
- Clear referral pathways communicated to all stakeholders
- Emotional and practical support for carers

Travel

- Outpatient care closer to home, with one person suggesting 80 miles would be the furthest they would travel to receive the best outpatient care
- People would travel any distance to access the best in-patient care
- Accommodation for families
- Financial support for those on a low income (travel, parking, radio and TV charges)

Communication

- Access to information that is easy to understand

- Good communication between all those involved in providing support
- The impact of terminology and language (e.g. people who access neuro-rehabilitation services do not like being referred to as a cohort and the term 'spasticity' clinics)

7 Outcome

7.1 The SWSCT has provisionally secured additional beds at both Frenchay BIRC and Oxford OCE. The RNHRD has stopped accepting new referrals and it is anticipated that all current inpatients will have been discharged by the end of March when the service will cease. In the event of a change in a patient's condition arrangements will be put in place to transfer them to BIRC or OCE.

7.2 There is ongoing work to ensure that any current outpatients are referred on to the service of their preference in a timely and uninterrupted manner. However, some outpatient services, such as hydrotherapy, will remain at RNHRD.

8 Expected Benefits

8.1 The additional capacity will be at centres that adhere to the nationally mandated specialised service specification, which outlines the quality standards to be achieved. This is the same specification to which the RNHRD would have worked.

8.2 There will not be a reduced level of capacity in the South West, which means that patients and their families will continue to have the same access to care.

9 Timescales and Next Steps

9.1 The additional capacity has been provisionally agreed to ensure continuity of service delivery.

9.2 The SWSCT is currently preparing 2013/14 contracts.

10 Summary

10.1 The RNHRD has given notice to commissioners that it will cease providing its neuro-rehabilitation service from the end of March 2013.

10.2 The South West Team of the South of England Specialised Commissioning Group has identified alternative providers able to provide a similar complex level of care and has engaged with patients and the public about the proposals.

10.3 It will be possible to re-provide the same level of neuro-rehabilitation capacity at the appropriate levels of complexity currently provided at the RNHRD at the alternative providers (BIRC and OCE for Level 1 care and a slightly wider range of providers for Level 2A care)

11 Recommendations

11.1 The B&NES Health and Social Services Overview & Scrutiny Committee is asked to:

- note that patients from the South West have and will continue to receive the best quality neuro-rehabilitation services that the NHS is able to provide;

- note there have been no issues regarding quality or safety in the RNHRD's decision to cease providing neuro-rehabilitation after the 31st March 2013;
- note the continued high level of quality care and family experience that the recommendations are able to support;
- note commissioners' collaboration with key stakeholders, including patients and the public as well as potential providers, in developing the recommended re-provision option;
- note that proposals should maintain the existing high quality of care without any adverse effect on current in-patients or future access to the service;
- support the proposal for service re-provision in the proposed centres.

Appendix A - Glossary

BIRC	The Brain Injury Rehabilitation Centre in Bristol provides comprehensive assessment, rehabilitation, therapy and community integration programme for people with physical and cognitive impairment and people with challenging behaviour following brain injury. We also provide SMART (Sensory Modality Assessment and Rehabilitation Technique) assessment for people who are in a minimally conscious state. More information about them can be found at: http://huntercombe.com/centre/frenchay-brain-injury-rehabilitation-centre/
BIRT	The Brain Injury Rehabilitation Trust in Swindon is a continuing rehabilitation centre that provides residential rehabilitation for adults with an acquired brain injury showing behavioural and/or cognitive deficits which in turn means lead to complex care needs. Service users may also have pre-existing or concurrent mental health problems in addition to their brain injury and may also be subject to detention under the Mental Health Act. More information about them can be found at: http://www.thedtgroup.org/brain-injury/news/new-service-in-swindon.aspx
CCG	Clinical commissioning groups are groups of GPs that will, from April 2013, be responsible for designing and commissioning local NON-SPECIALISED health services in England. They will do this by commissioning or buying health and care services including: • Elective hospital care • Rehabilitation care • Urgent and emergency care • Most community health services • Mental health and learning disability services
Commissioning	Term used to describe the overall process of planning, funding, procuring (purchasing), and monitoring of healthcare services.
Constraint-induced movement therapy	Constraint-induced movement therapy (CI or CIMT) is a form of rehabilitation therapy that improves upper extremity function in stroke and other central nervous system damage victims by increasing the use of their affected upper limb Types of restraints include a sling or triangular bandage, a splint, a sling. combined with a resting hand splint, a half glove, and a mitt. Determination of the type of restraint used for therapy depends on the required level of safety vs. intensity of therapy.
FES	Functional Electrical Stimulation is a method of using electrical

	stimulation to activate muscles that are weakened or paralysed as a result of neurological disease or injury, e.g. stroke, multiple sclerosis, traumatic brain injury. FES is most often used for the correction of drop foot.
General Medical Clinic	General clinic: all (except those a long distance away) patients ideally 6-8 weeks post discharge in the general clinic, also patients with behaviour, or cognitive or issues such as pain in the general clinic. Patients are referred from the community and from the current in-patient service.
Glenside	Glenside Neuro-rehabilitation Hospital provides a complete range of inpatient medical care and rehabilitation services to adults who are living with severe physical, cognitive or behavioural impairments, resulting from long-term neurological conditions including acquired or traumatic brain injury. More information about them can be found at: http://www.glensidecare.com/
Hydrotherapy	Hydrotherapy involves the use of water for pain relief and treatment. The term encompasses a broad range of approaches and therapeutic methods that take advantage of the physical properties of water, such as temperature and pressure, for therapeutic purposes, to stimulate blood circulation and treat the symptoms of certain conditions.
Inpatient	Inpatient care is the care of patients whose condition requires admission to a hospital.
Local Area Team	Ten of the NHS commissioning board's 27 local area teams will commission specialised services for their whole region.
Neuropsychology	Neuropsychology is the application of neuropsychological knowledge to the assessment, management, and rehabilitation of people who have suffered illness or injury (particularly to the brain). • A Consultant Clinical Psychologist provides an outpatient service one day per week to cover child, adolescent and adult outpatients. • Referrals are from the Consultant in Rehabilitation Medicine, GPs and Solicitors. Typical referral requests relate to assessment and intervention for level of cognitive, emotional or behavioural disorders with people with neurological conditions.
NHS Commissioning Board (NHS CB)	The NHS CB will, from April 2013, be responsible for designing and commissioning SPECIALISED health services in England through local area teams. Specialised services involve complex treatments or packages of care, often for relatively rare conditions. The services may involve the use of very specialised technology and equipment or drugs delivered by a specialist expert workforce. Some, but not all, specialised services are high cost. To be most safe and cost effective specialised services need to be planned and

	commissioned using populations of at least 1 million, which is larger than most Primary Care Trusts/CCGs, with many of the rarer conditions needing much larger planning populations than this. Consequently, specialised services are not provided in every hospital and tend to be found only in larger ones, which perhaps provide a range of specialised services.
OCE	The Oxford Centre for Enablement (OCE) provides specialist neurological rehabilitation services for patients with long-term conditions. More information about them can be found at: http://www.noc.nhs.uk/oce/
OSC	Overview and Scrutiny Committees – Committees established by Local Authorities with social services responsibilities to undertake their powers outlined in the Local Authority (Overview and Scrutiny Health Scrutiny Functions) Regulations 2002. Local Authority Overview and Scrutiny Committees are responsible for monitoring and regulating key service integration. NHS Trusts are required to consult with the Committee with respect to any proposed and significant changes to the pattern or location of local services. In summary, Overview and Scrutiny Committees can: • Review and scrutinise all matters relating to the planning, provision and operation of health services in the area of the local authority. • Make reports and recommendations to local NHS bodies and their local authority on any matter reviewed or scrutinised, and must be consulted by NHS bodies on any proposal for a substantial development or variation in health services. • Have matters referred to them by PPI Forums • Require the attendance of a local NHS body to provide information to them.
Out of Area	Outside of the South West of England
Outpatient	***Outpatient care*** describes medical care or treatment that does not require an overnight stay in a hospital or medical facility. There are several strands to the outpatient service for Neuro-rehabilitation: • General medical clinic • Spasticity clinic (Consultant led) • Physiotherapy (including FES) • Neuropsychology • Counselling • Splinting • Hydrotherapy
Plym(outh) Neuro	The Plym Neuro Rehab Unit is a 15 bedded inpatient neurological

Rehab Unit	rehabilitation unit for adults aged 16 years and over who have suffered an acquired brain injury, spinal cord injury and other neurological conditions. More information about them can be found at: http://www.plymouthcommunityhealthcare.co.uk/services/plym-neurological-rehab-unit
Poole Hospital NHS Foundation Trust	Neurological rehabilitation provides a service for both in-patients and out-patients. 1. For inpatients, an assessment and rehabilitation service is based on the acute medical wards including the acute stroke unit; 2. For outpatients, an ongoing rehabilitation service it offered to patients within the Poole area who have physiotherapy needs. More information about them can be found at: http://www.poole.nhs.uk/our_services/therapy_services.asp
PPE	Public and Patient Engagement refers to a variety of techniques used to ensure members of a community are given meaningful opportunities to influence the public services they receive.
Rehabilitation	Rehabilitation is the process of assessment, treatment and management by which the individual (and their family/carers) are supported to achieve their maximum potential for physical, cognitive, social and psychosocial function, participation in society and quality of living. Patient goals for rehabilitation vary according to the recovery trajectory and stage of their condition. Specialist rehabilitation is the total active care of patients with a disabling condition, and their families, by a multi-professional team who have undergone recognised specialist training in rehabilitation, led/supported by a consultant trained and accredited in rehabilitation medicine (RM) or neuropsychiatry in the case of cognitive / behavioural rehabilitation. Services are identified on the basis of complexity of their caseload. Generally, the severity of the condition is broken down into different categories as follows: • Four categories of rehabilitation need (categories A to D) • Three different levels of service provision Following brain injury or other disabling conditions: • The majority of patients have category C or D needs and will progress satisfactorily down the care pathway with the help of their local non-specialist rehabilitation services (Level 3). • Some patients with more complex needs (category B) may require referral to local specialist rehabilitation services (Level

	2b). • A small number of patients with highly complex needs (category A) will require the support of tertiary 'specialised' services (Level 1/2a). 'Tertiary specialist' rehabilitation services (Level 1) are high cost/low volume services which provide for patients with highly complex rehabilitation needs following illness or injury, that are beyond the scope of their local general and specialist services. These are normally provided in co-ordinated service networks planned over a regional population of 1 to 3 million through collaborative (specialised) commissioning arrangements. Level 2b-d are not specialised services and are therefore currently commissioned by Primary Care Trusts. Level 1 and 2a services are specialised and are commissioned by specialised commissioning groups.
Service Specification	Service specifications are drawn up by a commissioner before organisations are invited to put in applications to provide the service. Service specifications describe the service that the commissioner wants provided. They often set the standards required and may include things like staffing arrangements, skills, levels of activity, referral criteria, inpatient care and follow-up.
Sirona Care & Health Community Neuro & Stroke Service (Bath)	The neuro & stroke service can support you if you have had a stroke or have a long term neurological condition such as multiple sclerosis (MS), parkinson's disease (PD) or motor neurone disease (MND). The team has very experienced and skilled therapists, nurses and rehabilitation assistants who can provide advice, support and rehabilitation if you require this.
Social care	The range of services that support the most vulnerable people in society to carry on in their daily lives.
Spasticity Management Service	Physiotherapists have a specific role in the clinic that includes: • Helping to identify the potential for functional improvement through improved spasticity management • Liaising with community therapists regarding functional difficulties associated with spasticity and the benefit of intervention(s) implemented in the clinic • Recording appropriate outcome measures to evaluate the effectiveness of the clinical service and help guide future management • Providing follow up therapy as required; these are usually interventions not available to the patient locally and include Functional Electrical Stimulation, custom made splinting, Constraint Induced Movement Therapy and hydrotherapy.

Specialised Brain Injury Counselling	Specialised Brain Injury Counselling is psychological adjustment work for people who have had a brain injury and also for couples where one partner has a brain injury. It is very specialist and will only be funded where the work is over and beyond that which could be provided by a GP counsellor, or locally by the psychologist in the community team.
Splinting	People with acquired brain injury often experience decreased function in their upper limbs. Splinting is one of the intervention methods widely used to address these issues. Specialist splinting is performed by Neuro Occupational Therapists for patients following a brain injury who have require management of increased or decreased muscle tone. It is often in conjunction with the spasticity clinic to help increase or maintain range of movement. Patients require assessment and then a minimum of one follow up.
The Dean Neurological Centre, Gloucestershire	The Dean delivers specialist 24 hour nursing and therapy services for people with: • Complex long term neurological conditions • Brain or spinal injuries who require ongoing support and assistance to maximise functional ability More information about them can be found at: http://www.ramsayhealth.co.uk/pdf/The_Dean_Booklet_Web_Version.pdf

Appendix B - Neuro-rehab PPE Event Q&A Sessions

The closing of the unit:

What is happening to the staff that work at the unit and their expertise?
Kirstie Matthews, CEO at the RNHRD:

- Very conscious of the challenge the staff now face and acknowledge it is a very difficult and sad situation for all involved
- The Trust is working with all staff to redeploy and seek alternative employment

Has the medical profession been involved in the decision to shut the unit?
CEO at the RNHRD:

- *The decision was taken by the Board which includes our Medical and Nursing Directors*
- The number of patients admitted to the RNHRD and using the outpatient service has and continues to radically decline – 50% in recent years, and the lowest number of patients has been experienced in the last 2-3years
- A certain number of patients is required to support the running of a neuro-rehab unit which the Trust no longer experiences

Where are the patients from Hampshire that used to use the service going?
CEO at the RNHRD:

- Unfortunately I don't have that information to provide.

FES has been an important development for the Trust, what will happen to this facility? I received FES in the past and had an adverse reaction to it, what is in place to prevent this happening to other patients?
Corinne Edwards, Senior Commissioning Manager from B&NES PCT/CCG:

- Q1 – we (B&NES) are in discussion with Sirona to continue this service from 1st April.
- Q2 – There are clear clinical guidelines in place for the use of FES to ensure appropriate use.

What will happen to the training provided by the RNHRD for healthcare professionals in this field with regard the Wiltshire area?
Maddy Ferrari, Commissioner from Wiltshire PCT/CCG:

- Wiltshire CCG will be investing in GWH to provide training going forward but the finer details have not yet been established.

Has it just been good fortune that no new patients have been admitted to the RNHRD in the last two months or have you had to deny access to new patients?
Sue Davies, Acting Director of Specialised Commissioning:

- If the Trust identified that a patient would require treatment beyond the end of March these patients have been admitted to other centres. No waiting lists have been building up during this period.

Delegate comment to commissioners; an article was published in The Telegraph recently reporting that care of patients requiring neuro-rehabilitation was a postcode lottery, particularly in the South West where there is an under-provision of care. If neuro-rehabilitation is under provided in the South

West, why is the unit at the RNHRD being closed when there is clearly a demand; particularly as carer costs etc are far in excess of hospital provision of these services? The service, quality and approach at the RNHRD has been grossly underestimated and should not be disseminated across the region.

Acting Director of Specialised Commissioning:

- A piece of national work has been undertaken recently creating networks of trauma providers and reviewing how care is provided. For example in the South, trauma patients are taken to designated trauma centres at , Plymouth, Southampton, Oxford or Bristol.
- Part of this work means that trauma centres must now prescribe a patient's rehabilitation needs to establish for commissioners what needs to be provided for the patients' ongoing care.
- This encourages a much more joined up approach to working, which will be further enforced in April via the NHSCB. From April, under the NHSCB, there will be greater opportunities to improve services for neuro-rehab patients by working to nationally consistent standards.
- I have not seen the article and am not aware of a view that the South west is under-provided at this complex end of the care pathway. I accept that good rehabilitation can save costs for services and patients in the longer term.
- With regard maintaining the service at the RNHRD, the service has been affected by dropping patient numbers and patients moving away from the Trust. The Trust is a very small and it's financial cost base therefore much smaller than other Trusts. Extra money into the service would not solve the problem.

Dr Henderson-Slater, Clinical Director of OCE and consultant in neuro-rehab:

- The position of the RNHRD is not unique, neuro-rehabilitation centres must have a certain number of patients to remain a safe and effective unit because of the complexities of the service. Units cannot function as small units.

Delegate comment regarding the commissioning process: the commissioning of the service is being undertaken at the wrong level, i.e. Hampshire's decision to move provision to Glenside. The patient demand is still there but the pathway moved elsewhere.

Patients' needs:

Where will we have to go for new equipment or physio when it's not easy for us to travel?
Senior Commissioning Manager from B&NES PCT/CCG:

- Sirona will provide the outpatient service for B&NES patients inc splinting
- Sirona service will be equivalent to the service patients received at The Min

Will we continue to see our current Consultant(s)?

- Each patient will be reviewed on an individual basis and their health needs reviewed
- Will endeavour to ensure continuity and we are working closely with Sirona

Where will other neuro-rehab related services i.e. hydro, orthotics and bone density be provided from?
Chief Operating Officer from &aNES CCG:

- These will continue to be provided at the RNHRD

Comment from a delegate the meeting was not well advertised.
Acting Director of Specialised Commissioning:

- Explained the process of consultation requires a service model(s) to consult on hence why the meetings were called at this stage in the process.

Delegate comment regarding patient funding for travel; patients on low income have to make the journey for treatment before they are assisted with finance.
Acting Director of Specialised Commissioning:

- Agreed that this was an issue. Aware of some charities which might be able to assist with upfront costs.

Head of Public & patient Engagement for Specialised Commissioning:

- Some hospitals or local authorities provide hospital cars or transport free of charge. Funded by charitable means.
- Recognise that this information is often not provided immediately and that patients families often find out from other patients – means of communication need to be improved.

Delegate comment regarding patient funding for travel; travel is particularly difficult in rural areas where funding has been cut over the last few years.

The new service:

Delegate comment: planning a new service should be included in the planning of the closure of an existing service, not as an after thought. It is important to consider that neuro-rehab service cannot be included in a budget, they are expensive and you cannot put a price on the spend or cap it to meet budget restriction.

Comment from a delegate regarding replacing the service at the RNHRD with an equivalent service:
The team at the RNHRD are irreplaceable. If you really wanted to provide an equivalent service, this service should be running now in parallel to the current service to ensure the service is equivalent and to provide a baseline to evaluate the new service against.

What will happen to our medical notes?
Senior Commissioning Manager from B&NES PCT/CCG:

- These will transfer to your new outpatient service.

Are you working with 3rd sector organisations in planning our new service?
Head of Public & Patient Engagement for Specialised Commissioning:

- Some organisations that you will find in the glossary are 3rd sector
- We are working with a variety or organisations
- It is important to remember that once the NHS contracts an organisation to provide a service a standard of care is required regardless of who provides that service.

Are Sirona employing any of the RNHRD staff? It is really important to have continuity of Consultant because they know your details and history.
Senior Commissioning Manager from B&NES PCT/CCG:

- Aware that conversations have taken place with some staff members of the RNHRD and Sirona, but it is a matter for Sirona to pursue

Chief Operating Officer from B&NES CCG:

- Once the new service is confirmed an event will be held as an opportunity for patients to meet the new service staff

What will happen to the capacity at the hospitals that will take new neuro-rehab patients that would have been treated at the RNHRD, how will they cope with the extra patients?
Acting Director of Specialised Commissioning:

- The new centres are in the process of putting in additional beds.
- Transferring patients who would have been treated at the RNHRD to another service will not prevent other patients being treated because extra,beds are being created, rather than expecting existing capacity to cope.

How do we have confidence in the commissioning process for our service if Hampshire has not and does not send patients here?

Head of Public & patient Engagement for Specialised Commissioning:
The decision about where a patient receives treatment is not *always* specified and is dependent on patient choice:

- The patient decides what distance they are prepared to travel
- The patient wants the best care possible according to them and their needs
- From 1st April when the NHSCB is in place, commissioning will be more consistent across England which will allow for greater linkage between centres and a common standard of care across centres

Acting Director of Specialised Commissioning:

- OCE and BIRC offer a very good standard of all level services, comparable to the RNHRD

Dr Graham, Lead consultant at BIRC:

- BIRC is very similar to the RNHRD with an interdisciplinary team.
- Each patient is treated as an individual and their family and friends supported

Delegate comment regarding care at Frenchay; I had a terrible experience at Frenchay because I was seen by a consultant who was not involved with my case, the treatment was impersonal and damaging to my health.

Acting Director of Specialised Commissioning:

- Our job as commissioners is to ensure linkage in the care pathway and to try to prevent negative experiences like this occurring.

Health professional (delegate):

- I have worked with many neuro-rehab patients from a commissioning stance and can assure you that *all* patients feel the same passion you do about your unit; there are other excellent providers of this service *in addition to* the RNHRD.

Dr David Henderson-Slater, could you describe the facility at the OCE so we can get a feel for the service?

- Location: close to a ring road and 1.5miles from a train station.
- 26 beds, 16 allocated to the Oxford region, the remaining 10 take patients from out of area i.e. the South West.

- OCE has taken patients or provided some services to patients from out of region for a number of years now but not in the formal contracted environment that will be in place from 1st April 2013.
- OCE also provides prosthetic services for in and out of region patients.
- Has the capacity to provide more beds If required with minimal disruption
- Multi-disciplinary, large team approx 150 or all types of healthcare professional and a team of consultants with different but complimentary speciality interests.
- New building (approx 11 years old), built to high specification, low level of infection rate, excellent quality of care.

Delegate comment regarding repatriation; the repatriation of patients in area is difficult due to local capacity issues.

Acting Director of Specialised Commissioning:

- Work is required in region in April when the new organisations are in place to establish links between the providers/system and local areas.

Your thoughts on what you would like the new service to look like:

Tell us what you think is brilliant about your current service so we can put this in to your new service:

- The staff and the high level of care they give
- Physio's are highly skilled and personal
- Communication – internally and externally, particularly links with the community
- Holistic approach to patients and their involved friends and family

What do you think we can improve upon when designing your new service?

- Greater access to the RNHRD (or new service) once you have left the outpatient register, i.e. to self refer back to the service
- To spread the word about the capabilities and expertise of the staff at the RNHRD
- A joined up pathway/approach with:
    - Neuro-oncology
    - Young people – a specific pathway, accounting for their ability to be able to recover due to their age
    - Non-traumatic spinal injury
    - Mental health and acquired brain injury
    - Spinal cord injury
- Better support of family and friends to be able to support the patient
- With reference the Dorset service, but relating to the South West generally:
    - A specialised brain injury unit
    - A linking specialised acute unit and transition rehab unit
    - To follow a non-medical model – balance of power between clinician and patient led care model
    - Group and individual support sessions – to listened to in an open, encouraging and supporting environment
    - The ability to speak to all level of service user/provider, i.e. not be protected from some environments because it's not felt appropriate
    - Connected network of 'people who know', patients talking to patients, relatives talking to relatives
    - Range of information types that enables decision making

    - Families at the heart of the service
- Charities providing joint services with the NHS as opposed to just private organisations.

What would you like your new service to look like?

- One multidisciplinary centre that can provide all services
- Accommodation for family of patients on site who have to travel long distances
    - Support for relatives to make them feel safe and supported – emotional support, information about the local area
    - Comment from delegate: this support comes from having the *best* team looking after and treating the *individual.*
- Holistic approach
- Care plan post discharge – care seems to become dormant upon discharge from the hospital
  David Henderson-Slater:
    - Could look into the financial and clinical viability of opening a peripheral OCE clinic in the Bath/Bristol area. Sue Davies: we would need to review this idea in more detail to establish the volume of patients to support such a service
      Consultants are not encouraged to make routine follow up appointments with patients but for patients to make appointments as and when problems or issues arise. What do commissioners think of this process? Sue Davies commented that she would be open to reviewing this and had seen it work in high volume services.

Delegate comment regarding linking to local services; reiterated the need for providers linking with local services to ensure continuity of care for patients. Training for local services with the provider would be useful in establishing these links and ensuring continuity.

David Henderson-Slater:

- Brain injury patients often relapse after many years of improved health so it is important to links back into the service once a patient has been discharged.

How will the new service be funded within the new system and ensure that patients are not prevented or delayed treatment due to access criteria or similar?

Acting Director of Specialised Commissioning:

- Currently around the patch some services do require assessment prior to treatment, but it has been variable. We will be looking for a consistent approach. It is not yet clear whether there will be a formal assessment criteria in this area.

Chief Operating Officer from BaNES CCG:

- In B&NES assessment prior to treatment is undertaken but to ensure the patient is assigned to the most appropriate services.

Arthur Ling, commissioner for specialised commissioning:

- The team is working with CCGs to develop a consistent commissioning approach for the region. The NHSCB has developed a number of service specifications which can be used to assist this.

NHS Bath and North East Somerset

NHS Bath and North East Somerset Clinical Commissioning Group

Re-Provision of Outpatient Neuro-Rehabilitation Services

1 Purpose

This paper provides an overview of the current outpatient neuro-rehabilitation service at the RNHRD and the proposals to re-provide the non-specialised service including arrangements for communicating these changes to patients. The non-specialised elements of the outpatient service includes service arrangements for patients who are stepping down from more intensive follow-up arrangements at between 6-12 months after an inpatient stay and for patients who may have been referred for outpatient neuro-rehabilitation support from primary care. This could be by their GP or from another health care professional such as a district nurse.

(This paper should be read in conjunction with the South of England Specialised Commissioning Group's Briefing on the re-provision of the specialist Inpatient and Outpatient Neuro-rehabilitation service).

2 Description of service

There are several strands to the outpatient service for Neuro rehabilitation at the RNHRD. These include:

- General medical clinic
- Spasticity clinic (Consultant led)
- Physiotherapy (including Functional Electrical Stimulation)
- Psychology
- Counselling
- Splinting / orthotics

A description of each of these service components in set out in Annex 1.

3 Current Patient Activity

The current patient activity by geographical area that has been overseen by the Consultant led service is set out below in Table 1:

Table 1:

Primary Care Trust/ CCG Area	Total
B&NES	49
Wiltshire	54
Somerset	14
S. Gloucestershire	3
Bristol	4
Other	10
Total	134

This shows that the largest group of patients are from B&NES (37%) and Wiltshire (40%) and with 23% of patients coming from other geographical areas.

In addition there is a group of patients who are provided with outpatient therapy for physiotherapy and Functional Electrical Stimulation, Psychology, Counselling, Splinting and orthotics provision.

4 What is Important to Patients in Re-providing this Service?

The outputs from the patient engagement events that were held on Friday 1st March and Friday 8th March 2013 are set out in detail in attached accompanying papers. These events were very useful in identifying what is important to patients in re-provision arrangements. These include services that are:

- Patient centred and provide holistic care
- Are able to ensure there is excellent communication between service professionals within the team and with external professionals e.g. the patient's GP
- Focused on the needs of families as well as patients
- Have highly trained and experienced staff who understand patients conditions and can offer support and advice
- Staff have access to training to ensure they are providing the best possible care
- Links with voluntary sector organisations such as Headway are important

5 Re-provision Arrangements for Patients

This section of the paper describes an overview of re-provision arrangements for patients for all geographical areas but with more detailed information on future service arrangements for B&NES patients.

5.1 Future service arrangements for B&NES patients

From the 1st April 2013 an out-patient neuro-rehabilitation service will be provided by Sirona Care and Health. This is the current provider of community health and social care services for B&NES.

They currently provide a Community Neurological Rehabilitation & Stroke Service which supports patients who have had a stroke and for patients with other long term neurological conditions such as Multiple Sclerosis and Motor Neurone Disease.

Proposed Service model:

Due to the diagnoses of the patients requiring this service it is considered that day-time weekday clinics would be the most suitable for this client group. Based on patient activity reported by the RNHRD it is proposed that the following will be required;

- 1 x Clinical Specialist Physiotherapist (Band 7) OP session per week
- 1 x Orthotics / Clinical Specialist Occupational Therapist (Band 7) per month
- 1 x Consultant led OP clinic per week (2 x follow-up and review and 2 x spasticity management per month)
- 1 x Clinical Specialist Physiotherapist (Band 7) to attend spasticity management clinics (x2 per month)
- 1 x Clinical Specialist (Band 7) session per week to manage and support the assessment, monitoring, review and discharge planning of B&NES patients referred for admission to specialist brain injury units.

The service will be based in the Therapy department at St. Martin's Hospital in Bath. This has purpose built therapy facilities and offers good access to patients in terms of parking facilities. St. Martin's Hospital is approximately 3 miles and a 10 minute drive from the RNHRD and the centre of Bath.

At the request of NHS Somerset and Somerset Clinical Commissioning Group this service will also be provided to Somerset patients who have or would previously have been treated by the RNHRD for outpatient neuro-rehabilitation provision. This is for patients who are geographically based in the Mendip locality.

Service arrangements will be formally reviewed with Sirona after 6 months to ensure that the service is able to fully meet patients' requirements or sooner at either the request of B&NES Clinical Commissioning Group or Sirona Care and Health. However, it is the aim of commissioners and Sirona Care and Health to offer an equivalent and high quality service. This will be supported through an on-going engagement process with patients.

5.2 Future service arrangements for Wiltshire and patients from other geographical areas

From the 1st April 2013 an out-patient neuro-rehabilitation service for patients registered with a Wiltshire GP will be provided by Great Western Community Services, the current provider of community health care services in Wiltshire.

Patients from other geographical areas will be re-patriated back to local services. Commissioners from these areas have been provided with patient level lists of their patients including details of their care needs so that appropriate alternative arrangements can be made.

5.3 Other related and linked services at the RNHRD

The public engagement events highlighted that many patients were concerned about on-going arrangements for other services that are provided by the RNHRD but that form part of their overall care package. This included on-going arrangements for patients who have support from the Orthotic service provided by Mr Elmer and the hydrotherapy service.

These services will remain in place at the RNHRD and patients will be able to access these services in the usual way.

6 Communication with Patients about Future Service Arrangements

All affected patients have been contacted by the RNHRD to explain to them that the Neurological Rehabilitation service is closing after Thursday 28th March 2013 and that alternative arrangements are being put in place. Each patient will receive a further letter to advise them of the name and contact details of the new service provider. Patients will be advised that their clinical case records will be transferred to the new provider and that if they are not happy for their clinical details to be shared that they contact the RNHRD.

7 Equalities Impact

An equalities impact assessment on the re-provision of the non-specialised elements of the outpatients is being completed and the findings of which will be made available to the Well-being Policy Development & Scrutiny Panel on 22nd March 2013. (Unfortunately due to the timing and deadline of papers required for the meeting it was not possible to complete this analysis at the time of writing). The impact assessment will look at all protected characteristics.

8 Recommendations and Next Steps

The Well-being Policy Development & Scrutiny Panel is asked to note and comment on the re-provision arrangements for non-specialised outpatient neuro-rehabilitation services.

NHS B&NES PCT and Bath & North East Somerset Clinical Commissioning Group will continue to progress transfer arrangements for B&NES and Somerset patients to Sirona Care and Health and to continue to liaise with other commissioners to ensure that all patients have on-going arrangements in place.

Contact person	Tracey Cox, Chief Operating Officer, B&NES CCG. Tel 01225 831736, or Corinne Edwards, Senior Commissioning Manager for Unplanned Care & Long Term Conditions, B&NES CCG Tel: 01225 831868
Background papers	December 2012 Briefing to the Health and Well-being Panel on Neuro-rehabilitation services at the RNHRD
Please contact the report author if you need to access this report in an alternative format	

Annex 1 - Description of Outpatient Neuro-rehabilitation Services

Consultant Led Outpatients

- General clinic: all patients ideally 6-8 weeks post discharge in the general clinic, also patients with behaviour, or cognitive or issues such as pain in the general clinic. (Specialised services until 6-12 months post discharge).Patients are referred from the community (can be GP or AHP/community nursing) and from the current in-patient service.
- The spasticity clinic is led by a consultant supported by a physiotherapist. Some of these patients can be very complex and require an hour's appointment as they may need to be hoisted or have complex communication need e.g. touch sign language

Neuropsychology

Neuropsychology is the application of neuropsychological knowledge to the assessment, management, and rehabilitation of people who have suffered illness or injury (particularly to the brain).

- A Consultant Clinical Psychologist provides an outpatient service one day per week to cover child, adolescent and adult outpatients.
- Referrals are from the Consultant in Rehabilitation Medicine, GPs and Solicitors. Typical referral requests relate to assessment and intervention for level of cognitive, emotional or behavioural disorders with people with neurological conditions.
- Treatment packages are modular and consist of 4 to12 hour-long sessions depending on the requirements.
- Treatment delivery will be individually tailored and involve the patient with the carer/family if a behavioural component is required.
- Referrals are currently received at the rate of 2 per month.

Neurological Physiotherapy in the Spasticity Management Service

Experienced (band 7) physiotherapist's work alongside the medical team in the spasticity clinic as recommended in National Guidelines[1]. The physiotherapists have a specific role in the clinic that includes:

- Helping to identify the potential for functional improvement through improved spasticity management
- Liaising with community therapists regarding functional difficulties associated with spasticity and the benefit of intervention(s) implemented in the clinic
- Recording appropriate outcome measures to evaluate the effectiveness of the clinical service and help guide future management
- Providing follow up therapy as required; these are usually interventions not available to the patient locally and include Functional Electrical Stimulation, custom made splinting, Constraint Induced Movement Therapy and hydrotherapy.

Functional Electrical Stimulation (FES) Service

FES is a method of using electrical stimulation to activate muscles that are weakened or paralysed as a result of neurological disease or injury, e.g. stroke, multiple sclerosis, traumatic brain injury. FES is most often used for the correction of drop foot.

Experienced (Band 7) physiotherapists at the RNHRD are able to provide an FES service to patients who have funding approval from their local commissioning team. Provision is based on NICE and Royal College of Physicians guidelines[2,3].

An initial assessment is performed to establish if FES will be helpful in reducing the risk of trips/falls and in reducing the effort of walking. It may also be used as part of spasticity management, as an adjunct to botulinum toxin injections and in upper limb rehabilitation.

Outcome measures including walking velocity, falls efficacy scale and effort of walking are used to evaluate the effectiveness of the intervention.

If suitable, patients and/or their carer's are educated in the use of the device and issued with equipment to take home to assist their walking. Follow-up appointments are usually given at around 2 weeks, 6 weeks and 3 months for initial support in using the device. This is reduced to 6 monthly reviews to ensure appropriate and effective use of the FES device in the long term.

Specialised Brain Injury Counselling

The referrals are usually for psychological adjustment work for people who have had a brain injury and also for couples where one partner has a brain injury. It is very specialist and is provided where the work is over and beyond that which could be provided by a GP counsellor, or locally by the psychologist in the community team.

Splinting

Specialist splinting is performed by the neuro OTs for patients following a brain injury who have require management of increased or decreased muscle tone. It is often in conjunction with the spasticity clinic to help increase or maintain range of movement. Patients require assessment and then a minimum of one follow up

Bath & North East Somerset Council	
MEETING:	Wellbeing policy and development scrutiny panel
MEETING DATE:	March 22nd 2013
TITLE:	The Future of the Neuro Rehabilitation Services at the Royal National Hospital for Rheumatic Diseases
WARD:	ALL
AN OPEN PUBLIC ITEM	

1 THE ISSUE

The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust (RNHRD) took the decision in the November 2012 Board meeting to announce a "preference to close the neuro rehabilitation service subject to the necessary consultation". In December 2012 the Board, in public session, agreed that the "in-patient Neuro Rehabilitation service at the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust should cease being provided from 31st March 2013". In January 2013 the Board, in public session, agreed "that the Outpatient Neuro Rehabilitation service should cease being provided from 31st March 2013." Services will cease as of March 31st 2013. Commissioners are now consulting on where the specialist and non-specialist services will be re-provided.

2. RECOMMENDATION

Members are asked to note the information presented within the report as background and preparation to a following paper presented by the Specialised Commissioning Group and Primary Care Trusts on the future provision of services.

3. THE REPORT

3.1 Background

A Neuro Rehabilitation service has been provided as a national and specialist service at the RNHRD for many years. Over the past three years there has been a significant change in referral patterns as increasingly patients from outside the area who require less complex care are being treated closer to home. This change has led to a 50% reduction in income for this service over the last two years which has had a critical impact on the ability of the service to continue.

It is important to emphasise that there have been no concerns about the quality or safety of what has always been a well-regarded service. The position has arisen due to the recognition that the service is not financially viable now or in the future given the future intentions of commissioners.

RNHRD thoroughly evaluated potential responses to the financial challenge and continuously reviewed options for mitigating the financial risks to the service. In response significant changes in operational delivery were made but these changes were not able to improve the financial position and ensure a service that is financially viable.

3.2 Financial Position

The extent and reality of the financial position and the urgency to take action is highlighted through the financial reporting which indicated that the service was making a loss of on average £430k per annum.

This means that the service was not covering its direct costs (ie its staff and consumables) or making a contribution towards the costs of the estate and infrastructure that supports it. To recover this position, the service would need to be making a surplus of approximately £590k per annum.

These immediate service losses are in the context of the RNHRDs overall financial challenge where the organisation is currently losing £10k a day.

3.3 The Decision to Close

In taking its decision to close the service the RNHRD Board took account of these financial pressures and the necessity of responding to a financial position that has resulted in the organisation being found by Monitor to be in significant breach of one of its terms of authorisation. The Board also considered the described current South West Specialised Commissioning Teams intentions for in-patient neuro rehabilitation services at the RNHRD for 2013/14 which would have been based on this year's outturn, indications at the time were that this would have been unlikely to be higher than 8 beds based on activity to date. The Board has previously acknowledged that at this level of occupancy the service cannot be clinically or economically viable.

3.4 Engagement

RNHRD undertook an engagement exercise during November and December 2012. Comments were received from clinician's professional bodies, MPs and members of the public. These comments were taken into account in reaching the decision. An equalities impact assessment was also completed and taken into account. Supporting Board papers are available to view at http://www.rnhrd.nhs.uk/about-us/trust-documents.

3.5 Communications and Consultation

The RNHRD has communicated the service change widely with stakeholders and has collaborated closely with commissioners on the current consultation process. Work has taken place with all staff affected by the change, assisting individuals and seeking redeployment for as many people as possible. To date RNHRD has found alternative employment for 22 of the 64 employees placed at risk.

RNHRD has written to all patients informing them of the change in service and advising that further information will be provided on the re-provision of service as soon as this is clarified. All current patients have been reviewed and information will be sent to patient's GPs.

The commissioners are now consulting on the options for new provision for the specialist and non-specialist elements and the RNHRD is collaborating with this process as needed.

4. RISK MANAGEMENT

The change programme has been subject to a continuous risk evaluation process. Controls have been applied and risks managed through the RNHRD executive team and partner agencies.

5. EQUALITIES

An equalities impact assessment formed part of the process of evaluation and was taken into account in the decision making process.

6. CONSULTATION

An engagement was completed by RNHRD as described above. The engagement was internal for staff and external for public, patients, clinicians and stakeholders. Public consultation on re-provision is now being undertaken by the commissioners.

Contact person	Kirsty Matthews, Chief Executive RNHRD
Background papers	
Please contact the report author if you need to access this report in an alternative format	

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Bath & North East Somerset Council
MEETING: **WELLBEING POLICY DEVELOPMENT & SCRUTINY PANEL** MEETING DATE: **22nd March 2013**
TITLE: **WORKPLAN FOR 2013/14**
WARD: All
AN OPEN PUBLIC ITEM
List of attachments to this report: Appendix 1 – Panel Workplan

1 THE ISSUE

1.1 This report presents the latest workplan for the Panel (Appendix 1).

1.2 The Panel is required to set out its thoughts/plans for their future workload, in order to feed into cross-Panel discussions between Chairs and Vice-chairs - to ensure there is no duplication, and to share resources appropriately where required.

2 RECOMMENDATION

2.1 The Panel is recommended to

(a) consider the range of items that could be part of their Workplan for 2013/14

3 FINANCIAL IMPLICATIONS

3.1 All workplan items, including issues identified for in-depth reviews and investigations, will be managed within the budget and resources available to the Panel (including the designated Policy Development and Scrutiny Team and Panel budgets, as well as resources provided by Cabinet Members/Directorates).

4 THE REPORT

4.1 The purpose of the workplan is to ensure that the Panel's work is properly focused on its agreed key areas, within the Panel's remit. It enables planning over the short-to-medium term (ie: 12 – 24 months) so there is appropriate and timely involvement of the Panel in:

a) Holding the executive (Cabinet) to account

b) Policy review

c) Policy development

d) External scrutiny.

4.2 The workplan helps the Panel

a) prioritise the wide range of possible work activities they could engage in

b) retain flexibility to respond to changing circumstances, and issues arising,

c) ensure that Councillors and officers can plan for and access appropriate resources needed to carry out the work

d) engage the public and interested organisations, helping them to find out about the Panel's activities, and encouraging their suggestions and involvement.

4.3 The Panel should take into account all suggestions for work plan items in its discussions, and assess these for inclusion into the workplan. Councillors may find it helpful to consider the following criteria to identify items for inclusion in the workplan, or for ruling out items, during their deliberations:-

(1) public interest/involvement

(2) time (deadlines and available Panel meeting time)

(3) resources (Councillor, officer and financial)

(4) regular items/"must do" requirements (eg: statutory, budget scrutiny, etc)?

(5) connection to corporate priorities, or vision or values

(6) has the work already been done/is underway elsewhere?

(7) does it need to be considered at a formal Panel meeting, or by a different approach?

The key question for the Panel to ask itself is - can we "add value", or make a difference through our involvement?

4.4 There are a wide range of people and sources of potential work plan items that Panel members can use. The Panel can also use several different ways of working to deal with the items on the workplan. Some issues may be sufficiently substantial to require a more in-depth form of investigation.

4.5 Suggestions for more in-depth types of investigations, such as a project/review or a scrutiny inquiry day, may benefit from being presented to the Panel in more detail.

4.6 When considering the workplan on a meeting-by-meeting level, Councillors should also bear in mind the management of the meetings - the issues to be addressed will partially determine the timetabling and format of the meetings, and whether, for example, any contributors or additional information is required.

5 RISK MANAGEMENT

5.1 A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

6 EQUALITIES

6.1 Equalities will be considered during the selection of items for the workplan, and in particular, when discussing individual agenda items at future meetings.

7 CONSULTATION

7.1 The Workplan is reviewed and updated regularly in public at each Panel meeting. Any Councillor, or other local organisation or resident, can suggest items for the Panel to consider via the Chair (both during Panel meeting debates, or outside of Panel meetings).

8 ADVICE SOUGHT

8.1 The Council's Monitoring Officer (Divisional Director – Legal and Democratic Services) and Section 151 Officer (Divisional Director - Finance) have had the opportunity to input to this report and have cleared it for publication.

Contact person	Jack Latkovic, Senior Democratic Services Officer. Tel 01225 394452
Background papers	None
Please contact the report author if you need to access this report in an alternative format	

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Appendix 1

Last updated 13.03.13.

Wellbeing Policy Development & Scrutiny Panel Workplan

Meeting Date	Agenda Item	Director	Report Author	Format of Item	Requested By	Notes
22nd Mar 13						
	Pre-meeting at 9.30am					
	Cabinet Member Update (15 min)		Cllr Allen			
	CCG update (15 min)		Ian Orpen			
	LINk update (15 min)		Diana Hall Hall			
	HealthWatch and Independent Complaints Advocacy Service (ICAS) (15 min)		Su Bowen			
	Homelessness and Temporary Accommodation (30 min)		Graham Sabourn			Cllr Tim Ball invited for this item
	Neuro-Rehabilitation Services (2 hrs)		Specialised Commissioning Team			The RNHRD and the RUH requested to be present for this item
17th May 13	Cabinet Member Update (15 min)		Cllr Allen			
	CCG update (15 min)		Ian Orpen			
	JSNA – topic ?		Jon Poole			
	New Health Commissioning arrangements		CCG (officer tbc)			
	NHS 111		Liz Hersch (CCG) - tbc			
	Strategic Transitions		Mike	presentation		

			MacCallam			
	The Royal National Hospital for Rheumatic Diseases – Update on the Acquisition		The RUH rep (CEO?)			
	Mental Health Support Services		Andrea Morland			
26th Jul 13	Cabinet Member Update (15 min)		Cllr Allen			
	CCG update (15 min)		Ian Orpen			
	JSNA – topic ?					
	6 monthly review/update on Urgent Care		Ian Orpen			
	Talking Therapies update		Andrea Morland			
20th Sep 13	Cabinet Member Update (15 min)		Cllr Allen			
	CCG update (15 min)		Ian Orpen			
	JSNA – topic ?					
	Dementia Strategy update		Sarah Shatwell/Corinne Edwards			
22nd Nov 13	Cabinet Member Update (15 min)		Cllr Allen			
	CCG update (15 min)		Ian Orpen			
	JSNA – topic ?					
17th Jan 14	Cabinet Member Update (15 min)		Cllr Allen			

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	CCG update (15 min)		Ian Orpen			
	JSNA – topic ?					
21st Mar 14	Cabinet Member Update (15 min)		Cllr Allen			
	CCG update (15 min)		Ian Orpen			
	JSNA – topic ?					
Future items						
	Alcohol Harm Reduction SID - recommendations		tbc			Due to LR departure it is added to future items
	Dentistry				Panel	Arising from 28th January 2013 mtg
	Sexual Health				Cllr Clarke request	Arising from 28th Jan mtg
	Home Care				Cllr Jackson request	Arising from 28th Jan mtg

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